Health Care Financing Grants & Contracts Report

Trends in State Administration of Medicaid Programs

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TRENDS IN STATE ADMINISTRATION OF MEDICAID PROGRAMS

by

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This report was made pursuant to Purchase Order No. HCFA-M78-0449 between the Health Care Financing Administration, Department of Health, Education, and Welfare and the author.

The Project Officer for this contract was Diane Rowland, Office of Research, Demonstrations, and Statistics.

INTRODUCTION

This paper is an overview of current and proposed State Medicaid policies as of late 1978.

The Health Care Financing Administration wanted to have up-to-date information on the extent of coverage of the poor in the various states, the degree to which Medicaid meets the needs of the poor (in terms of population covered and services provided) and the extent of coverage of the poor by supplementary health programs using State and local funds. Also, information was needed on possible changes in Medicaid coverage being considered by the States.

The specific aims of the study which resulted in this paper were;

- to identify potential changes and trends in eligibility criteria for Medicaid,
- to compare the use and operation of the spenddown provision for the medically needy among states,
- to review current and potential benefit restrictions under Medicaid,
- to report State activity to restrict payment of hospital, physician or other services, and
- to ascertain the extent of coverage of the poor who are not eligible for Medicaid.

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Introduction:

On July 25, 1978, a letter was sent to Medicaid directors in the 53 jurisdictions advising them of the contract study and requesting their cooperation. A significant number of Medicaid directors responded; other Medicaid directors were contacted by telephone to arrange field visits.

The original study design had contemplated visits to 12 states. Because of the importance of the study subject, and because of a desire to obtain as broad a view of trends as possible, 28 states were ultimately visited. These states represent a broad cross-section of Medicaid programs. (A list of the states reviewed and field visit dates is included as Appendix 1.)

Nearly all directors were extremely cooperative. Many reserved significant amounts of staff time for the project. (A list of the staff consulted with in each state is included as Appendix 2.) Others assembled necessary data in advance of the field visit in order to expedite the study. Subsequent to the field visit, each state Medicaid director was provided with a copy of the draft report for his/her state in order to verify its accuracy.

The study was handicapped, however, in several ways. Some states, presently undergoing significant changes in their Medicaid programs, refused to participate in the study. In several other states, Medicaid agency staff had

only the most general ideas of program eligibility. This is a result of contracting out most eligibility functions to the state welfare agency. In addition, most states had little or no information available on the expenditures for state-only or locally-funded medical care programs. That information is essential for determining the impact of proposed changes in the state Medicaid program on health care for indigents and on state and local health care budgets.

Two final caveats should be noted. First, the field visits on this project were conducted prior to the November, 1978 elections. In some of the states reviewed, "Proposition 13"-type measures were on the ballot. In others, voting trends and increased expenditures have combined to threaten new cutbacks in their Medicaid programs. This study does not reflect those changes. Second, because of time constraints, it was not possible to independently verify the information provided by state Medicaid agency staffs.

1. Potential changes and trends in eligibility criteria for Medicaid.

a. Are states changing income criteria?

Most states have been increasing income criteria for their Medicaid programs. Generally, this is not done on an ordered basis, however. Cost-of-living increases often bear no relationship to the actual increases in the cost-of-living. Often one category of recipient will receive

a cost-of-living change while other categories are frozen. (See California.) This discriminatory treatment is most often directed against families with children.

As a practical matter, therefore, income criteria have been reduced relative to the change in cost-of-living. In many states, AFDC levels continue to be computed on a percentage ratable reduction (see Maine, Mississippi, Wisconsin) and/or on the basis of need standards that are as much as 10 years old. (See Delaware, Maine, New Hampshire.)

Many states strongly criticized the use of SSI standards to determine Medicaid income eligibility. This criticism was directed at two aspects. First, SSI criteria were criticized as extremely confusing and difficult to administer. Most states pointed to the deeming regulations as an example. (See New York.) Second, most states found the Social Security Administration even less responsive to the need for technical assistance on eligibility issues than HCFA (their words).

b. Are states changing resource criteria?

Resource criteria have generally been increased since the advent of the SSI program. Most states have increased resource criteria to SSI levels, although some states still have some differences. AFDC resource levels continue to lag far behind the adult aid categories.

One of the interesting findings in the

study was the ingenuity of many states in avoiding unwanted SSI criteria. The situation in which one spouse becomes institutionalized provides a good example. Several states indicated that the HEW Regional Office had notified them that a home, owned in joint tenancy by the institutionalized and non-institutionalized spouse, could only be exempted for a maximum of six months. Almost no states applied that standard, however, due to the hardship it would create for the non-institutionalized spouse and dependent children, if any. (See California, Oregon.)

Several states simply ignore the HEW directives. (See Alabama, Florida.) Others treat the institutionalized spouse as part of an AFDC family budget unit (whereas s/he would normally be treated as SSI-linked) absent from the home on a temporary basis. (See Hawaii, Michigan, Minnesota.) Other states treat the joint tenancy interest as worthless, since no one would buy a one-half share. (See Maine.) Other states treat the property interest as inaccessible, thereby rendering the asset worthless. (See New Hampshire.)

Most states visited had transfer of asset prohibitions. These provisions applied to transfers ranging from within 1 year to 5 years of applying for Medicaid. Two different types of penalties are imposed. Some states disqualify applicants for a specified period. (See Minnesota, New Mexico, Oklahoma.) Other states disqualify

the applicant for a variable period based on the prorated value of the transferred resource. (See California, Colorado, Nebraska.) Some states provide for a waiver of these penalties. (See Mississippi.) Many 209(b) states pointed to their transfer provision as one of the main reasons that they became 209(b) states. (See Virginia.) Some states have no transfer prohibition. (See Florida, Hawaii, Kansas, Maine, Wisconsin.)

Most states utilize one of two systems of resource standards. In many states, certain classes of resources are exempt and other non-exempt resources must be worth less than specified resource levels. (See Washington.) Other states add in an additional tier by subjecting some non-exempt resources to a specified maximum value in addition to the general resource level. (See New Mexico.) Automobiles are a common example of this type of resource. (Nebraska also places a home in this category if it is "unusually luxurious.")

One common focus of criticism was the SSI policy with regard to burial plots. Most states strongly urged more generous exemptions to reduce mental hardship for elderly recipients. (See Florida.)

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

While some states are providing Medicaid for all "Ribicoff children," many states are including only

subclasses. (See Appendix 3.) One common complaint was the lack of guidelines for determination of the reasonableness of classifications. This related, most frequently, to the desire by states to include children receiving general assistance. (See Delaware, Illinois.)

One of the unique approaches with regard to "Ribicoff children" was the use of this option to aid unborn children. One state treats unborn children as "Ribicoff children." (See New York.) This allows the state to provide Medicaid for the unborn (and to meet most other health needs of the mother which would affect the unborn) even if the mother is in an intact family and has no categorical linking.

d. Are unborn children covered? Are there plans to change such coverage?

Most states covered unborn children, although the beginning date of eligibility varied greatly. (See Appendix 4.) Several states acknowledged that eligibility was postponed until after the first trimester (or coverage was excluded completely) in order to limit use of the Medicaid program for abortions. (See Virginia.)

Other states noted problems with obtaining prenatal care. (See Florida, Maryland.) Even in those states that include prenatal care in the delivery fee (see Delaware, New Hampshire), it is not clear that services are always being provided and/or that beneficiaries know of

their availability.

In addition, there are significant differences between the states as to what income standard is to be used, i.e., whether the unborn child's needs are to be considered in establishing financial criteria. (Compare Michigan and New Jersey.) One state provides coverage for unborn children independent of the eligibility of the mother. (See Kansas.)

e. What is status of coverage of AFDC-UF families?

Most states cover families with unemployed fathers. (See Appendix 5.) Many states provide coverage significantly beyond the federal standard and extend non-federally assisted AFDC and/or Medicaid eligibility to families in which the father is workin g mo e than 100 hours per month, but receives insufficient income from employment. (See California, New Jersey.)

f. Are states proposing changes in operation of spenddown?

Most states are not making significant changes in their spenddown programs. Those states that are revising their spenddown programs are generally doing so in order to come into compliance with federal law. (See Hawaii, Illinois, Maryland.) Only one state expressed real satisfaction with the operation of its spenddown program. (See Oklahoma.)

g. What are states doing with regard to 209(b) option?

Few states are considering major changes with regard to the 209(b) option. (See Appendix 6.) South Carolina had considered the option and agency staff rejected it. Mississippi is considering abandoning the 209(b) option.

One interesting feature was that in many 209(b) states, income criteria have steadily been increased to SSI levels or greater. (See Utah.) Resource standards, except for transfer prohibitions, also generally parallel SSI standards. (See Hawaii.) Some states still utilize significantly lower resource standards, however. (See Oklahoma.)

2. Compare use and operation of spenddown provision among states.

a. Are states changing income lines or operation of spenddown?

As indicated, states have generally increased income lines on a limited basis. Operation of spenddown programs is not changing significantly.

b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

In all states surveyed, spenddown under the 209(b) option is being administered in the same manner as

the medically needy spenddown.

c. What groups use the spenddown provision? How is public informed about spenddown provision?

Few states had any demographic characteristics on the populations using the spenddown. In those states that had data, approximately 85-90 per cent of the spenddown population were aged or disabled, with the overwhelming portion aged. Most of the medically needy program expenditures were attributable to institutional care, primarily nursing homes.

Few states conduct any outreach with regard to their medically needy programs. (Louisiana and Maine are exceptions.) Most administrators acknowledged that outreach for institutionalized patients is unnecessary since institutional providers are familiar with the requirements of the spenddown program and can expedite eligibility processing. Satisfying spenddown liabilities with institutional bills is also relatively easy. Few ambulatory eligibles learn about the spenddown program, however, and even fewer can manage the applicable eligibility hurdles.

d. How is spenddown administered?

A wide variety of problems were identified with regard to the spenddown program. The most common problem identified was the difficulty that ambulatory patients have in qualifying under the program. Most states operate, in effect, two spenddown programs. One program,

usually utilizing a one-month accounting period, is applied to institutionalized patients. The other program, usually utilizing a three to six-months accounting period, is applied to ambulatory patients. (See Minnesota, Nebraska.)

The problems of ambulatory applicants assembling sufficient medical bills to satisfy a three to six-months accounting period was noted in several states. This problem was especially serious in the ambulatory care setting because, unlike in the hospital setting, providers are usually unwilling to extend credit.

Many problems with treatment of spenddown liabilities were noted. One state was carrying over excess income from month-to-month. (See Kansas.) As a result, if a beneficiary did not utilize the medically needy program in one month because excess income did not equal expenses, this excess income was added on to the liability for future months.

A common problem related to treatment of expenses incurred outside the accounting period, but still owed. At least two HEW Regional Offices had indicated that these expenses had to be included in computing liability for a current accounting period. Few states applied this policy. (See Kansas.)

Another question related to coverage of retroactive expenses. Some states were utilizing a flexible accounting period so that a beneficiary could include

retroactive months if it was to his/her advantage. (See Kansas, Louisiana.) Several HEW offices indicated that this was improper, but states complained that there does not seem to be any authority for this view and that it runs counter to the previously stated policy. (See Mississippi.)

The question of whether states can credit only the Medicaid rate, rather than actual costs, for incurred expenses is still unsettled. In those states that limit incurred expenses to Medicaid reimbursement rates, beneficiaries must incur medical expenses far in excess of their legal liability. (See Kansas.) A related problem arises where a beneficiary has made payment directly to a provider and Medicaid coverage is now available to reimburse those expenses. (See Wisconsin.)

Many states complained about their problems with chronological tracking of bills. Often a beneficiary will come in with a handful of bills. The case workers must assemble these bills in chronological order and insure that no previous expenses were incurred. This usually results in additional recalculations of spenddown liability. Those states indicated a desire to utilize bills as they were provided to the agency. (Oklahoma does not utilize chronological tracking and cited its practice as part of the reason for the successful management of its medically needy program with a one-month accounting period.)

Those states that do chronological

tracking of bills complained about the requirement of "splitting" bills. (See Maine.) If an applicant satisfies and exceeds his liability in a single bill, the state is supposed to cover the portion of the bill above the liability. Some states begin coverage at the beginning of the day in which the liability is satisfied (see Mississippi); some states begin coverage with the bill which meets or surpasses the liability (see New Hampshire); some states actually split the bills. (See Minnesota.) Many states complained about the problems this poses for the fiscal agent. (See Louisiana.)

Limits on "reasonable" services were another problem. While HEW regulations seem to authorize states to limit expenses incurred for the liability to reasonable levels, there are no real guidelines for this review. As a result, some states have attempted to limit "reasonable" expenses to those reimbursed under their Medicaid plans. (See Louisiana.)

Some states acknowledged that they had been directed to recompute liabilities if income changed during the accounting period or if the beneficiary brought in additional expenses. (See New Mexico.) At least one Regional Office disagreed with this view, and most states also acknowleged that this was not being done. (See Kansas.)

Significant questions were raised

regarding the income standard to be used during the first month of institutionalization for 300% nursing home cap eligibles. HEW regulations indicate that the SSI standard must be used. Few states are complying with this requirement and view it as a serious disservice to the beneficiary. (See New Mexico.)

Despite the advent of MMIS, few states have an adequate system to insure that medical expenses used to satisfy the spenddown liability are not being reimbursed once eligibility is established. (See Hawaii.) Some states, however, are developing excellent systems to prevent fraud or abuse. (See Oklahoma.)

One issue that arose during the study was income criteria for medically needy families. Although many states recognize the needs of the unborn in computing financial eligibility for cash assistance, the needs of the unborn are often excluded in determining medically needy eligibility. As a result, medically needy income standards in some cases are more restrictive than applicable AFDC standards. (See Michigan, Utah.) In another state, cash assistance levels in several counties were higher than medically needy levels. (See New York.)

Finally, several states indicated that HEW needs to take some stand regarding the treatment of spenddown liability as a premium. Several states, perhaps emboldened by Utah's continuing example, have begun utilizing

this policy. (See New York, Illinois.) Other states continue to require paid bills rather than incurred expenses. Whatever policy is decided on, there is a need for uniform enforcement.

3. Current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

Only a few states are presently considering new limits on scope of services. (See Alaska, Washington.) Most states went through their most serious fiscal crises during 1974-1975. Significant cutbacks were implemented during that period. Now, however, these same states have begun to recoup some of the cutbacks from that period. Despite rising costs, most state administrators indicated a recognition that there are no easy solutions to rising Medicaid expenditures. Coverage of abortions is an exception to this rule. (See California, Michigan, Minnesota.)

Many states continue to apply limits on services that are unrelated to medical necessity. Thus, a limit on hospital inpatient days may be imposed despite a recognition that medically necessary care is not being reimbursed. (See Alabama, Oregon.) Some attention should be addressed to the question of whether such limits should be tolerated because of the effect that they have on the medical

integrity of the program.

Many states are also struggling with some way to limit utilization by beneficiaries of emergency rooms as their primary care providers. (See Louisiana.) This problem is compounded by the low physician reimbursement levels in many states which have resulted in low participation rates. (See Colorado, Florida.) Some states are considering or are already applying limits on services which may be provided in hospital emergency rooms. (See Kansas, New Mexico.) Other states are considering limits on the number of visits which can be authorized. (See Louisiana.)

b. <u>What changes are anticipated in coverage of optional services?</u>

Few states are considering significant expansions of optional services. Some states are considering significant restrictions in coverage of optional services. (See Washington.) Most state administrators indicated that their state programs are in a holding pattern while the Carter Administration decides what it is going to do about national health insurance. At least one state administrator indicated a concern that expanding coverage now would hurt the state in the future if a "maintenance of effort" provision was included in the NHI proposal.

c. <u>Are copayments being imposed? If so, at what level and on what services?</u>

Many states indicated a strong philosophical opposition to copayments. (See Louisiana, Minnesota, Oklahoma.) Other states indicated that their experiences with copayments had left them unconvinced that copayments are effective in controlling unnecessary utilization. (See New Mexico.) Other states indicated strong philosophical support for copayments regardless of their cost-effectiveness. (See Alabama.) (A list of those states utilizing copayments is included as Appendix 7.)

Several states mentioned the problem of imposing copayments on EPSDT services. These states do not have a system of segregating EPSDT services so that copayments are not imposed. This is especially true of prescription drugs for children. Some states have attempted to exempt individuals under the age of 21 from copayment requirements. (See New York.) Other states admitted that copayments do end up frequently being imposed on EPSDT services. (See Maryland.)

Several states have also attempted unsuccessfully to exempt institutionalized recipients from copayments. At least one state administrator was shocked to find out that beneficiaries in her state are paying for drug copayments out of their maintenance needs allowance. Several HEW Regional Offices have taken the position that the "comparability" provision requires copayments to be imposed on all classes of recipients. (See Virginia.) Attention

needs to be addressed to the question of whether institutionalized recipients can be legally required to pay for copayments out of their maintenance needs allowances.

d. Is prior authorization being imposed?

Prior authorization is being generally used. Several states indicated strong support for prior approval systems as a means of insuring a broad scope of services with adequate fiscal controls. (See Minnesota.) One state administrator expressed a philosophical opposition to prior authorization systems. (See Oklahoma.)

Few states had any guidelines for reviewing prior authorization requests. One state acknowleged that the service must be medically necessary and, in addition, that there must be sufficient funds available to justify payment. (See Oregon.) Other states impose standards unrelated to medical necessity such as employability for certain services. (See Kansas.)

One additional problem related to compliance with the notice and fair hearing regulations. Some HEW offices have indicated that notice must be provided to the beneficiary of prior authorization denials. This notice must include an explanation of fair hearing rights. Few states comply with this requirement. (A list of those states providing notice is included as Appendix 8.)

4. Activities within state to restrict payment of

hospital, physician, or other services.

a. Are physician fees being limited?

Physician fees are being limited in most of states. This is accomplished through several methods. Some states use a maximum fee schedule. Other states have not updated physician profiles in several years. In a wide variety of states, this has taken its toll on provider participation. (See Colorado, Florida, New Hampshire, New Jersey.)

A large number of states indicated strong support for negotiated statewide fee schedules. (See New York.) Other states indicated that as a first step HEW should establish uniform procedure codes so that information could be utilized from other payers within the state and exchanged between state Medicaid agencies.

b. Are formularies for drugs being restricted?

Most states have not significantly restricted formularies for legend drugs. Some states are imposing restrictions on a wide variety of drugs such as anorexants, however. (See California, Louisiana.) Even in such states, reimbursement is usually available with prior authorization. (See Nebraska.)

The major trend over the past few years has been a restriction of formularies with regard to non-legend drugs. A number of state administrators

acknowledged the cost-ineffectiveness of this approach. In many cases, for example, Darvon is being prescribed because of the nonavailability of aspirin as a covered service.

Most states are now reimbursing pharmacies for legend drugs based on MAC or EAC plus a dispensing fee. Some states are still utilizing a cost plus system. (See Minnesota.) Some states apply maximum allowable costs to drugs in addition to the MAC drugs. (See California, New York.) In nearly all states visited, dispensing fees have recently been increased.

c. Other restrictions on payment?

A wide variety of states are utilizing rate-setting commissions (see Illinois, New York, Wisconsin), and an even larger number of states are discussing prospective rate reimbursement mechanisms. (See Alaska, Michigan.) A few states indicated strong support for prudent buyer approaches. (See Colorado.)

5. Extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 percent state funding?

In several states visited, non-Medicaid eligibles are eligible for a program similar to the Medicaid program. (See California, Minnesota, Oregon.) In these states non-Medicaid eligibles include general assistance recipients and other individuals and families who are not

categorically-linked, but who are medically indigent. In some states, these medical assistance recipients are restricted to a more limited scope of services than are the state Medicaid eligibles. (See South Carolina.) At least two states provide services under their general assistance medical care programs that are not available under their Medicaid programs. (See Alaska, Wyoming.)

Several states have extensive state-administered or locally-administered public hospital systems to serve indigents. (See California, Louisiana.) In some states, these facilities supplement the general assistance medical care program. (See California.) In other states, these facilities are the primary source of care for non-Medicaid eligibles. (See Mississippi.)

In several other states, counties or other units of local government administer small budgets to meet the medical needs of indigents. (See Alabama, New Hampshire, New Mexico.) Generally these programs are administered on a case-by-case basis.

b. <u>What are the sources of care for medically indigent adults? How many receive services? At what cost?</u>

Several states visited had catastrophic health insurance programs. (See Alaska, Maine, Minnesota, New York.) These programs are financed with state funds and require substantial expenditures by the patient before state

eligibility is established. Once eligible, patients remain liable for substantial coinsurance amounts.

Very limited data was available on the extent of coverage with non-federal funds. The data that was available indicated present expenditures of at least two billion dollars. This generally includes only funds expended through state-assisted medical care programs. That figure probably only scratches the surface, however. Local responsibility needs to be addressed as a separate project in order to develop reliable data on the extent of state and local expenditures for health care.

States Visited

Alabama	September 13, 1978
Alaska	September 21, 1978
California	July 25, August 4, 1978
Colorado	August 15, 1978
Delaware	October 10, 1978
Florida	September 29, 1978
Hawaii	September 25, 1978
Illinois	September 11, 1978
Kansas	September 12, 1978
Louisiana	September 15, 1978
Maine	October 4, 1978
Maryland	August 23, 1978
Michigan	September 8, 1978
Minnesota	September 6, 1978
Mississippi	September 28, 1978
Nebraska	August 11, 1978
New Hampshire	October 5, 1978
New Jersey	September 25, 1978
New Mexico	September 19, 1978
New York	October 6, 1978
Oklahoma	September 27, 1978
Oregon	August 30, 1978
South Carolina	August 10, 1978
Utah	August 14, 1978
Virginia	August 24, 1978
Washington	August 31, 1978
Wisconsin	September 7, 1978
Wyoming	August 16, 1978

APPENDIX 1

State Agency Staff Consulted

ALABAMA

Clayton Schmidt - Chief, Medical Services
Arthur Miller - Director, Compensation Management
Henry Vaughn - Administrator, Internal Affairs
Helen Wylie - Director, Planning and Development
Wanda Russell - Associate Director, Medical Certification
Sam Hardin - Associate Director, Pharmaceutical Program

ALASKA

Dave Davidson - Public Assistance Program Officer

CALIFORNIA

Doris Soderberg - Chief, Eligibility Branch (Medical Care Standards Division)
Wade Williams - Chief, Benefits Branch (Medical Care Standards Division)
Don Knifong - Project Director, Medical Eligibility Redesign System Project - Eligibility Data System
Leonard Terra - Pharmacist, Pharmaceutical Program Consultant (Benefits Branch)

COLORADO

Barbara Ford - Assistant Director, Medical Assistance
Patty Floyd - Chief, Appeals and Recovery
Myrle Myers - Chief, Pharmacy
Paula Gonzalez - Administrative Officer II

DELAWARE

Richard Cherrin - Administrator, Social Services
Anne Gray - Administrator, Social Services
Patricia Phillips - Administrator, Social Services

FLORIDA

Wright Hollingsworth - Acting Supervisor, Utilization Control
Bill Little - Supervisor, Program Planning and Development (Medical Services)

Bill Brattain - Program Supervisor, Supplemental Security Income/Public Assistance
Dr. Gates - Medical Supervisor, Family Health Program

HAWAII

Robert Millar - Medical Care Administrator
Earl Motooka - Medical Welfare Specialist

ILLINOIS

Jane Snowden - Special Assistant to the Director
Mary Ann Langston - Acting Policy and Planning Administrator
Bill Opper - Chief, Bureau of Policy Procedures
Pat Kain - Assistant Deputy Director, Division of Medical Programs
Karen Liska - Supervisor, Bureau of Policy Procedures
Wayne Epperson - Chief, Bureau of Research and Statistics

KANSAS

Katie Hauck - Supervisor, Medical Eligibility Program
Robin Smith - Director, Public Assistance Section
Leslie Van Sickle - Research Analyst III, Research and Statistics
Kathryn Klassen - Director, Medical Services Section
Sandy Barrie - Administrative Officer

LOUISIANA

Bonnie Smith - Director, Medical Assistance Program
Walter McLean - Assistant Director, Medical Assistance Program

MAINE

Ron Stoodley - Director, Medicaid Eligibility
Jim Lewis - Assistant Director, Bureau of Medical Services
Mike O'Donnell - Coordinator, Drug Program

MARYLAND

Seldra Damon - Chief, Division of Program Review and Planning (Medical Care Program)
Ned Wollman - Chief, Division of Eligibility - Medical Assistance Policy (MCP)

MICHIGAN

Bruce Hansen - Director, Medicaid Policy (Division Medical Services Administration)
Ken Hargrove - Director, Medical Eligibility
Steve Scheer - Director, Office of Program Development and Reimbursement
Jan Salmons - Supervisor, Medical Assistance
Dexter Andrews - Director, General Assistance Section

MINNESOTA

Robert Randle - Director, Medical Assistance (Bureau of Income Maintenance)
John Buch - Chief, Pharmaceutical Services
Warren Nyhus - Supervisor, Policy and Planning
Beth Lehmann - Policy Specialist

MISSISSIPPI

Bill Allen - Deputy Director, Medicaid Commission
Martin White - Assistant Director, Medical Services (Medicaid Comm.)
Frances Euart - Director, Assistance Payments (Department of Public Welfare)

NEBRASKA

Don Hogg - Chief, Medical Services Division
Marge Wallace - Chief, Division of Income Maintenance
Fay Shalla - Assistant Chief, Division of Income Maintenance
Gloria Gosch - Supervisor, Quality Control

NEW HAMPSHIRE

Calvin Wentworth - Acting Deputy Director, Medical Services
Judy Nicholson - Assistant Chief, Medical Social Services
Arthur Stukas - Assistant Director, Assistance Payments

NEW JERSEY

Allan Wheeler - Deputy Director, Division of Medical Assistance & Health Services
Bill Lopatin - Pharmaceutical Consultant
Larry Strand - Chief, Bureau of Prepaid Health Plans
Peggy Kerchner - Chief, Procedure Development and Communications

NEW MEXICO

Joseph Flynn - Bureau Chief, Medical Assistance

NEW YORK

Dick Cody - Director, Eligibility and Local Monitoring Section
Bill Steibel - Deputy Commissioner, Division of Medical Assistance
Bob Skerrett - Bureau Director, Medical Assistance
Ruth Bongiovanni - Senior Social Services Program Specialist
John Johnson - Senior Social Services Program Specialist

OKLAHOMA

Bertha Levy - Administrative Assistant Supervisor, Medical Unit
J.D. Burton - Program Supervisor, Assistance Payments
David Jones - Assistant Coordinator, Medical/Medicaid
Dickye Mines - Coordinator, Medical Social Services
Evelyn Greenman - Assistant Supervisor, Crippled Children's Unit

OREGON

Mike Kane - Manager, Health and Social Service Section (Adult & Family Services Division)
Dick Arbuckle - Assistant Manager, Health and Social Services Section (Adult and Family Services Division)

SOUTH CAROLINA

Virgil Conrad - Commissioner
Charles Oswald - Chief, Medical Assistance
Blanche McCullough - Executive Assistant, Health Care Financing
Eugene Rinaldi - Project Administrator, Medical Assistance
Leonard Sternbach - Planner III
Lyle Brown - Coordinator, Assistance Payments
John Molan - Project Administrator, Medical Assistance

UTAH

Pat Wilde - Manager, Bureau of Program Operations
Ken Parker - Coordinator, Planning and Support
Gene Hoffling - Eligibility Coordinator, Assistance Payments
Gus Panos - Assistant Director, Assistance Payments

VIRGINIA

Ann Cook - Director, Medical Social Services
Mac Perkins - Administrator, Professional Services Section
Bill Sydnor - Administrator, Dental Medicaid

WASHINGTON

Patsy Brittain - Supervisor, Professional Audit and Systems Section
Bob Hall - Chief, Medical Assistance
Liz Benedict - Supervisor, Medical Program Specialist

WISCONSIN

Martin Preizler - Director, Bureau of Health Care Financing
Lowell Trewartha - Director, Bureau of Planning and Implementation

WYOMING

Ernie Rumpf - Director, Medical Assistance
Jermy Wight - State Administrator, Public Assistance/Social Services
Elizabeth Myers - State Program Manager, Public Assistance

Coverage of Ribicoff Children

Alabama	Some
Alaska	Some
California	All
Colorado	Some
Delaware	Some
Florida	Some
Hawaii	Some
Illinois	Some
Kansas	Some
Louisiana	Some
Maine	All
Maryland	All
Michigan	All
Minnesota	All
Mississippi	Some
Nebraska	Some
New Hampshire	Some
New Jersey	All
New Mexico	Some
New York	All
Oklahoma	All
Oregon	Some
South Carolina	Some
Utah	All
Virginia	Some
Washington	All
Wisconsin	All
Wyoming	None

APPENDIX 3

Coverage of Unborn Children

Alabama	Yes (1st Month)
Alaska	None
California	Yes (1st Month)
Colorado	Yes (1st Month)
Delaware	Yes (9th Month)
Florida	Yes (1st Month)
Hawaii	Yes (1st Month)
Illinois	None
Kansas	Yes (1st Month)
Louisiana	Yes (4th Month)
Maine	None
Maryland	Yes (1st Month)
Michigan	Yes (1st Month)
Minnesota	Yes (7th Month)
Mississippi	Yes (5th Month)
Nebraska	Yes (1st Month)
New Hampshire	None
New Jersey	Yes (1st Month)
New Mexico	Yes (4th Month)
New York	Yes (4th Month)*
Oklahoma	None
Oregon	Yes (4th Month)
South Carolina	Yes (1st Month)
Utah	Yes (1st Month)
Virginia	None
Washington	Yes (1st Month)
Wisconsin	Yes (1st Month)
Wyoming	Yes (4th Month)

* Unborn child treated as Ribicoff child during months 1-3.

APPENDIX 4

Coverage of Unemployed Fathers

Alabama	None
Alaska	None
California	Yes*
Colorado	Yes
Delaware	Yes
Florida	None
Hawaii	Yes*
Illinois	Yes
Kansas	Yes*
Louisiana	None
Maine	Yes
Maryland	Yes
Michigan	Yes
Minnesota	Yes
Mississippi	None
Nebraska	Yes
New Hampshire	None
New Jersey	Yes*
New Mexico	None
New York	Yes*
Oklahoma	None
Oregon	Yes*
South Carolina	None
Utah	Yes*
Virginia	None
Washington	Yes
Wisconsin	Yes
Wyoming	None

* Coverage also is provided for families not eligible under federal law.

APPENDIX 5

States Surveyed Electing the 209(b) Option

Alabama	No
Alaska	No
California	No
Colorado	No
Delaware	No
Florida	No
Hawaii	Yes
Illinois	Yes
Kansas	No
Louisiana	No
Maine	No
Maryland	No
Michigan	No
Minnesota	Yes
Mississippi	Yes
Nebraska	Yes
New Hampshire	Yes
New Jersey	No
New Mexico	No
New York	No
Oklahoma	Yes
Oregon	No
South Carolina	No
Utah	Yes
Virginia	Yes
Washington	No
Wisconsin	No
Wyoming	No

APPENDIX 6

States Utilizing Copayments

Alabama	Drugs
Alaska	None
California	None
Colorado	None
Delaware	None
Florida	None
Hawaii	None
Illinois	None
Kansas	Drugs
Louisiana	None
Maine	None
Maryland	Drugs
Michigan	Dental and Vision
Minnesota	None
Mississippi	None
Nebraska	None
New Hampshire	None
New Jersey	None
New Mexico	Drugs and Dental
New York	None
Oklahoma	None
Oregon	None
South Carolina	Drugs, DME, Chiro., Pod., Dental
Utah	None
Virginia	Drugs
Washington	None
Wisconsin	None
Wyoming	None

APPENDIX 7

States Providing Notice to Recipients of Prior Authorization Denials

Alabama	No
Alaska	Yes (but not FH rights)
California	No
Colorado	No
Delaware	No
Florida	No
Hawaii	Yes
Illinois	No
Kansas	No
Louisiana	No
Maine	Yes
Maryland	No
Michigan	No
Minnesota	Yes
Mississippi	Some (long term care)
Nebraska	No
New Hampshire	Yes (but not FH rights)
New Jersey	Yes
New Mexico	No
New York	No
Oklahoma	Not applicable
Oregon	No
South Carolina	No
Utah	No
Virginia	No
Washington	Yes
Wisconsin	Yes
Wyoming	No

APPENDIX 8

ALABAMA

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

No changes are expected in income criteria under the Alabama program. No information was available on cost-of-living changes in the cash assistance program.

Alabama uses a $383 cap for institutionalized recipients. This represents a benefit level of $363 plus a $20 income disregard. If an individual has less than $383, they spenddown to the $25 level for institutionalized recipients. If an individual has over $383, there is no eligibility.

Some optional supplement recipients do not receive Medicaid.

   b. Are states changing resource criteria?

Resource limits are set at the same level as for SSI. Under state law a transfer of property prohibition is applied to AFDC and Medicaid recipients pursuant to Act No. 803. This is a 2-year transfer of asset prohibition with an intent requirement imposing a 2-year disqualification period. It was effective May 23, 1977. This Act applies to all inter vivos gifts of assets where the donor is left without sufficient funds to purchase necessities, and is not limited to Medicaid. (A copy of this Act is included as Alabama-1.)

In the situation where one spouse becomes institutionalized, Alabama continues to exempt the house so long as it is occupied by a dependent relative. HEW has taken exception to this policy on the grounds that the state cannot continue to exempt the home after 6 months of institutionalization.

   c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Alabama provides Medicaid for those financially eligible children under age 21 for whom public agencies are assuming full or partial responsibility in foster homes or private child-caring institutions.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are included in the state AFDC and Medicaid plans upon medical verification of pregnancy. A proposal to begin coverage at the beginning of the third trimester was defeated. No changes in the present coverage are expected.

e. What is status of coverage of AFDC-UF families?

Families with unemployed fathers are not included in either the Alabama AFDC or Medicaid programs.

f. Are states proposing changes in operation of spenddown?

Alabama does not have a spenddown program.

g. What are states doing with regard to 209(b) option?

Alabama is a 1634 state. There was some consideration of choosing the 209(b) option by the legislature, but they were persuaded that this was not a cost-effective approach. This was due to the lack of sufficient staff and the high administrative cost of the program.

2. Compare use and operation of spenddown provision among states.

Alabama does not have a medically needy or 209(b) spenddown.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

Alabama imposes a number of limits under its Medicaid program. Hospital inpatient services are limited to 20 days, with a possibility of a 10-day extension. Regardless of medical necessity, inpatient services are not extended beyond 30 days. This limitation does not apply to individuals under the age of 21. Inpatient physician services are limited to 1 visit per day;

nursing home visits are limited to 1 per month. No limit is imposed on outpatient visits except medical necessity pre-payment review.

Because the state has no licensing law, home health services are limited to non-profit agencies (Title XVIII agencies). These are generally county health departments or United Way agencies.

The staff indicated that no non-emergency transportation was provided under the state plan. Alabama also did not pay for any Medicaid abortions last fiscal year.

Limits are specifically described in Alabama Medicaid Regulations 78-1. (A copy of these regulations is included as Alabama-2.)

b. What changes are anticipated in coverage of optional services?

No major changes are expected in coverage of optional services. The staff indicated that there will almost certainly be no expansion of coverage. Although 1975 was the period of most severe fiscal problems in the Alabama Medicaid program, the staff indicated that the program continues to be hard-pressed.

c. Are copayments being imposed? If so, at what level and on what services?

Alabama imposes a $.50 copayment on each prescription and refill. This does not apply to family planning supplies or EPSDT services. The staff indicated strong support for copayments, but acknowledged that there have been no studies on the cost-effectiveness of this approach. Regardless of cost-effectiveness, however, the staff indicated a desire to see it extended to physician services.

d. Is prior authorization being imposed?

Prior authorization is imposed on a variety of services. These include nursing home placements, hospitalization for dental services, out-of-state services, special lenses for eye care, non-emergency transportation, hospitalization in non-PSRO hospitals, some periodontal services for EPSDT, and durable medical equipment. In addition, prior authorization is required for prescription drugs which are not included in the formulary. Drug requests are filed by the physician.

They usually initiate it by telephone with a follow-up letter with the name of the pharmacy which will dispense the drug. The authorization is provided directly to the pharmacy. (A copy of the notice sent to the pharmacy is included as Alabama-3; a copy of the notice sent to the fiscal intermediary is included as Alabama-4.)

Requests for prior authorization of durable medical equipment utilize a different process. The physician sends a request to the home health agency which transmits the request to the Medical Services Administration in Montgomery.

Prior authorization turn-around time is almost immediate. Ordinarily, authorization is received over the phone. In the case of denials, there is no notice to the beneficiary. In level-of-care determinations where the beneficiary requests a hearing, continued assistance is provided at the pre-existing level.

Services subject to prior authorization are specifically described in Alabama Medicaid Regulations 78-1. (Alabama-2.)

4. Identify and assess activity with state to restrict payment for hospital, physician, or other services.

   a. Are physician fees being limited?

Physician services are reimbursed at 1976 levels based on 1975 profiles. Reimbursement is limited to the 75th percentile of usual and customary charges in 1975. No budget increase has been approved for increased physician reimbursement. The staff noted problems with physician participation due to maldistribution aggravated by the low fees.

Some move is being made towards a statewide fee schedule. This will be done on a negotiated basis. A statewide fee schedule is also being considered for dentists, who are somewhat more open to the proposal. The state uses the CPT-4 to describe procedures.

   b. Are formularies for drugs being restricted?

Alabama uses a two-part formulary. If a drug is not described in the formulary, prior authorization is required. Both legend and non-legend drugs are included. As indicated, prior authorization can be provided for drugs not described in the formulary. The dispensing fee

increased to $2.25 effective October 1, 1977. No maximum or minimum dosages are included in the state plan. (A copy of the Alabama Drug Code Index is included as Alabama-5.)

c. Miscellaneous.

Nursing home reimbursement is limited to the 60th percentile of costs for that type of home. There has been no real consideration of a rate commission or prospective rate setting to control hospital costs.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Individual counties budget funds for medical expenses. These are based on individualized determinations of need. Otherwise, there are no public benefits.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

The staff indicated that there are a variety of public hospitals and clinics scattered throughout the state which are available to meet some health care needs of indigents. Principal reliance, however, is placed on hospitals serving indigents writing off the services as bad debts.

ALASKA

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

a. Are states changing income criteria?

Effective July 1, 1978, SSI benefit levels, including state supplement levels were increased by the percentage increase in the cost of living. AFDC levels were also increased effective July 1, 1978 by a flat $50 per family budget unit in those families including adults. Grants for families without adults were not increased. Budget levels are set by the state legislature by statute.

One unusual feature is a $50 state statutory limit on the maximum amount of relative responsibility which may be imposed for beneficiaries in state institutions. The Regional Office has objected to this as a violation of federal law, but no compliance issue has yet been raised.

Cash benefit levels for adult aid recipients are set forth in a May 5, 1978 Memorandum (included as Alaska-1). AFDC benefit levels are set forth at regulation 3211 (included as Alaska-2).

b. Are states changing resource criteria?

SSI resource levels are used for determining eligibility for optional state supplements. AFDC resource limitations are $500 in cash. Non-exempt non-cash personal property and non-income producing non-exempt real property are limited to $1,000 in value. Basic exemptions are similar to the SSI standards. The staff noted a significant administrative problem with eligibility determinations where applicants own fishing boats, snowmobiles and fishing permits. Often a fishing permit may equal $40,000 to $50,000 in value. Despite this, it may not be in use because of a broken fishing boat or for other reasons. Snowmobiles, which ordinarily are recreational vehicles, may be the necessary mode of transportation in many areas.

There is no transfer of asset prohibition in Alaska law. In the situation where a spouse enters a nursing home, the state continues to exempt the institutionalized

spouse's share of the home if occupied by a needy spouse or dependent child. This is true beyond the first 6 months of institutionalization.

Resource levels are described at regulation 3210 (included as Alaska-3).

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

The following sub-class of "Ribicoff children" is aided: (1) children for whom public agencies are assuming full or partial financial responsibility and who are in foster homes or private child-caring institutions, (2) children in intermediate care facilities for the mentally retarded, and (3) children in inpatient psychiatric facilities. This last category went into effect in April of 1978. There is some consideration of further expansion.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are not covered under either the state AFDC or Medicaid plan. The staff explained that the Public Health Service covers Alaskan natives through a large string of hospitals. There is therefore no real push for unborn child coverage since Alaskan natives have coverage and the assumption is that other poor persons leave the state. There is therefore no inclination to change the coverage although the staff indicated that some of the assumptions are no longer correct.

e. What is status of coverage of AFDC-UF families?

Families with unemployed fathers are not covered under either the AFDC or Medicaid plans. The staffed viewed this program has an incredible administrative hassle compounded by a lack of effort by state employment services. Despite seasonal jobs in Alaska, the staff indicated that such a program would mostly affect Alaskan natives who are already aided by the Bureau of Indian Affairs.

One unusual additional aspect is that in AFDC families deprived of parental support or care by reason of the physical or mental incapacity of a parent, only one parent is covered for AFDC and Medicaid. The family budget unit must exclude one parent from coverage

although either the incapacitated parent or other parent may be excluded. The problem is in predicting which parent will require Medicaid coverage later.

f. Are states proposing changes in operation of spenddown?

The only spenddown in the Alaska program is the 300 per cent nursing home cap. Although the staff was not certain of this point, it appears that the 300 per cent cap is used from the first month of application. Alaska uses a 1 month accounting period with concurrent month budgeting. Beneficiaries receive a $25 need allowance plus a $4.00 pass-along of income.

g. What are states doing with regard to 209(b) option?

Alaska has never been a 209(b) state and has no intention of becoming one. This is consistent with the expressed view of maximizing federal financial participation. The staff indicated that there is no real pressure to establish a medically needy program at this time.

2. Compare use and operation of spenddown provision among states.

Alaska has no medically needy or 209(b) spenddown program.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

No limits are presently imposed under the Alaska program. Regulations, however, are being written for the first time. The staff indicated that Oregon limits will be included. These would include a 21-day hospital stay limit per calendar year with extensions for medical necessity. Medical necessity determinations would be made by the PSRO. Cosmetic surgery is excluded under the plan although the definition of "cosmetic" is being established. There is also some thought of limiting office visits.

b. What changes are anticipated in coverage of optional service?

Alaska has no present intention to establish a Medicaid drug program. Rural health clinics were recently added by act of the legislature. There are presently 2 certified clinics. The state added outpatient surgicenters this past year. In Alaska the legislature decides by statute the scope of services.

c. Are copayments being imposed? If so, at what level and on what services?

No copayments are presently being imposed and there is no consideration of copayments at this time.

d. Is prior authorization being imposed?

Prior authorization is imposed on a variety of services. These include: cosmetic surgery, contact lenses, medical transportation, inpatient hospitalization of more than 21 days, long-term care placements, hearing aids, and speech, hearing, and language disorder treatment therapy.

Providers submit authorization request forms to the Medical Practice Review Section in the central office. These requests are reviewed by a medical review officer. If denied, the beneficiary receives a copy but no explanation of his/her fair hearing rights. Turnaround time for authorization requests is under 2 weeks. (A copy of the general service request form is included as Alaska-4. A copy of the nursing home form is included as Alaska-5.)

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physician fees are not being limited. Physicians are paid on the basis of usual and customary charges up to Medicare limits. Profiles are developed through tape-to-tape exchange with the Medicare fiscal intermediary. Physicians are paid at the 75th percentile of usual and customary charges. These profiles are updated every 6 months. Most physicians use the 1969 California RVS although there is some transition to 1974 procedure codes. Fees are already computed on a statewide basis.

b. Are formularies for drugs being restricted?

There is no Medicaid prescription drug program.

c. Miscellaneous.

The staff indicated some movement to establish a statewide rate-setting commission like Washington. Rates would be set on a prospective basis using a uniform cost accounting system.

Home health services are limited to Title XVIII certified agencies. There is only 1 in the State of Alaska. This is run by the municipality of Anchorage.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Alaska has a general relief medical care program. Income standards are slightly less than categorical standards. There had been some legislative expression to exclude employables from the program. Since this was not specifically provided in any statute, this exclusion is not expected to be implemented although it is contained in proposed regulations. Eligibility standards are set forth in the regulations at section 2006. (A copy is included as Alaska-6.)

Services provided under the general relief medical care program include drugs for Title XIX and non-Title XIX eligibles. Reimbursement is based on provider charges. Inpatient services, outpatient services, long-term care, physician services, physical therapy, emergency dental care, eyeglasses, voluntary sterilization, and prosthetic devices are provided under the program. Occupational therapy is currently included but will be eliminated in the near future.

The total cost for the general relief medical care program is approximately $6 million per year including expenditures for both Title XIX and non-Title XIX eligibles.

In addition, Alaska has a catastrophic illness program. Application is made to a Catastrophic Illness Committee. This Committee consists of a medical review officer from

the Department of Health and Social Services, a member who has suffered a catastrophic illness, and a representative of the Department of Commerce and Economic Development. This Committee determines the applicant's share based on income and resources available. Coverage is limited pretty much to expenses in excess of $1,000. The provider must also agree to a payment plan from the applicant.

Expenditures exceeded $.5 million in the last fiscal year. Presently, the catastrophic illness program pays charges but there is some movement to limit reimbursement to Medicaid rates.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to the general relief medical care program and catastrophic illness program, the Public Health Service, CHAMPUS, state hospitals for psychiatric services and ICF-MR are the main sources of care for medically indigent individuals. In addition, Hill-Burton hospitals provide additional services for indigents.

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

California normally increases income criteria for the Medicaid program effective July 1 each year. As a result of Proposition 13, income criteria were not uniformly increased effective July 1, 1978. SSI beneficiaries including optional supplement recipients, received a pass-on of the federal cost-of-living increase plus a smaller (3.2 per cent) cost-of-living increase on the state share. AFDC income standards were frozen at pre-July 1, 1978 levels by the legislature. As a result, medically needy levels (which are set at 133-1/3 per cent of the AFDC levels) were also frozen. There has been some subsequent consideration by the state legislature of raising the frozen income levels. (Medically needy levels are included as California-1.)

   b. Are states changing resource criteria?

No changes are expected in resource requirements under the California Medicaid program. California utilizes a 2-year transfer of asset prohibition which is applicable to all Medicaid recipients. Transfers within 2 years of the date of application for less than adequate consideration are presumed to be for the purpose of establishing eligibility or reducing the share of cost.

In such cases, an indefinite period of ineligibility results. The duration of ineligibility is based on pro-rating of the value of the uncompensated property based on the monthly maintenance need level for that size of family. Actual medical expenses of the family, costs of out-of-home care, and costs of necessary home repair, can be used to reduce the value of the property being prorated. A transfer more than 2 years prior to applying for assistance is ordinarily irrelevant unless there is evidence that conflicts with this presumption. (See California-2.)

California exempts a home for the medically needy. Although AFDC cash assistance standards do not exempt a home, an AFDC-linked family could establish eligibility under the medically needy program. One car is also exempt under the medically needy program. Again, this is more liberal than the AFDC cash assistance standard. Non-exempt property is limited to $1,500 for an individual, $2,250 for 2 persons, $2,300 for 3, and $100 additional for each additional person.

In a situation in which one spouse becomes institutionalized, California continues to exempt a home if occupied by the long-term care patient's spouse or dependent children. (See California-3.)

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

California provides Medicaid for all financially eligible children under the age of 21. Different subclasses of "Ribicoff children" must meet different standards of eligibility. For example, individuals who are not linked to one of the categorical programs, or who are at least 18 but not more than 21 and would be linked to AFDC except that the parent or parents refuse to apply for Medicaid, and individuals not determined eligible for Medicaid under other categories or as a medically needy person because of a pending application based on blindness or disability must meet income and resource standards applicable to the medically needy. Children in foster care for whom a public agency is assuming financial responsibility in whole or in part, or children receiving aid for adoption of children are eligible without regard to the medically needy standards. (See California-4.)

d. Are unborn children covered? Are there plans to change such coverage?

California provides AFDC and Medicaid to families with unborn children upon medical verification of pregnancy. The unborn child is treated as an additional person in the family budget unit.

e. What is status of coverage of AFDC-UF families?

California provides AFDC and Medicaid to families with unemployed fathers based on the federal definition of unemployment. In addition, families that cannot meet the federal definition may be eligible under the California Medically Indigent Adult Program.

f. Are states proposing changes in operation of spenddown?

Some changes are being considered in the operation of the California spenddown program. California is in the process of redesigning its eligibility sub-system for greater utility in the claims payment process, faster collection of data, and more efficient access to data. One of the ideas being considered is to have on-line terminal capability to generate Medicaid cards in the

local office. This approach would allow eligibility workers to compute liability for spenddown in the computer, enter incurred medical expenses directly (and prevent reimbursement for bills used to establish the liability), and generate a Medicaid card immediately once the liability is satisfied.

There has also been some talk of changing from a monthly accounting period back to a quarterly accounting period. In 1970, as part of the Medi-Cal Reform Act, the state shifted from a monthly accounting period to a quarterly accounting period. Effective July 1, 1976, the state shifted back to a monthly accounting period. No other major changes are being considered.

g. What are states doing with regard to 209(b) option?

California is a 1634 state but is now exploring the possibility of applying more restrictive criteria. Social Security Administration determinations would be supplemented by state determinations for SSI/SSP applicants who would be potentially affected by the more restrictive criteria.

2. Compare use and operation of spenddown provision among states.

a. Are states changing income lines or operation of spenddown?

As indicated, medically needy levels have been frozen since July 1, 1977. Future increases are likely, but Proposition 13 has created an uncertain atmosphere for continued expansion of the Medicaid program.

b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

California is not a 209(b) state.

c. What groups use the spenddown provision? How is public informed about spenddown provision?

California does no real outreach regarding the spenddown program. Most individuals learn about the spenddown program through a provider, generally an institutional provider. (A copy of the informational pamphlet is included as California-5.)

California has done some studies of the demographic characteristics of the medically needy population. Except for income criteria, which indicates the number of families with income under the medically needy

maintenance need level, the other characteristics do not distinguish between spenddown eligibles and other medically needy persons. Available socio-economic characteristics are described in the "Medically Needy Point-In-Time Study" (included as California-6).

3. Identify and analyze current and potential benefit restrictions under Medicaid.

   a. What limits are being considered on amount of service?

California lifted restrictions on physician office visits on July 1, 1975. Most other medical care services are available subject to utilization controls. The most typical control is prior authorization. A few services such as eye appliances are subject to prepayment review at the fiscal intermediary. Some providers, including chiropractors, psychologists, independent speech therapists or occupational therapists are limited to a maximum of two visits per month to any one of these practitioners.

Outpatient services are unlimited only as they apply to physician services. Any other outpatient service is limited by the controls applied to the particular professional discipline. Limits on drugs were lifted only for those drugs included in the state formulary. All non-formulary drugs require prior authorization.

Additional utilization controls may be imposed in the aftermath of Proposition 13 pursuant to Assembly Bill 1096 (included as California-8). California is also considering seeking a waiver of the freedom-of-choice requirement.

   b. What changes are anticipated in coverage of optional services?

July was a period of considerable turmoil in the California Medicaid program. A number of changes were considered by the state in the wake of Proposition 13. One legislative committee had proposed eliminating all optional services from coverage. The state legislature ultimately deleted $11 million for elective surgery. How this will be accomplished is not yet certain.

The state does not view a second opinion requirement as cost-effective. Prior authorization already exists for many inpatient services. As a result, field consultants often get a second opinion. One possibility being considered is to move certain surgery presently done on an inpatient basis to outpatient settings. Another possibility is to have prior authorization for some outpatient surgeries.

Abortions were cutback effective July, 1978, to standards more restrictive than the federal standards. This is presently being attacked in court. A number of drug cutbacks are also being considered. These are discussed in Question 4b.

The staff had proposed prior authorization for small diopter changes for vision care services. This was voted down by the legislature. A proposal for mass purchasing of drugs was also recently killed. The state had also considered a prudent buyer approach to hospital services. A study indicated that this would not work in California since 28 hospitals do 44 per cent of the business with the state. The staff indicated that the state is moving instead toward individually negotiated prospective rate reimbursement.

The staff indicated that the main focus for the short-run in post-Proposition 13 California will be to control inappropriate utilization through S/UR review and to control excesses by providers.

c. Are copayments being imposed? If so, at what level and on what services?

Copayments were imposed on prescription drugs and outpatient physician visits from January 1, 1972, through June 30, 1973. The staff indicated little support within the department for reimposing copayments.

d. Is prior authorization being imposed?

As previously indicated, prior authorization is imposed on a variety of services. Prior authorization is performed generally by field consultants. Some of the services which are subject to prior authorization include hemodialysis services, nursing home care, dental services, hearing aids, medical transportation, artificial limbs and braces, inpatient hospital care, and durable medical equipment. Beneficiaries are not presently notified of denials of requests for prior authorization. This is presently under court challenge.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

California is presently using the 1974 California RVS. All 1974 RVS numbers are either converted to 1969 counterparts or are adjusted to correspond to related 1969 RVS procedures. Each unit is reimbursed at either

$.64 for most office and institutional physician procedures, and $.69 for procedure codes 90,000 through 90,470. Different conversion coefficients are used for surgery, radiology, etc.

Fees were going to be increased on July 1, 1978 by 6 per cent. This was eliminated as a result of Proposition 13. Provider fees have therefore been frozen since October, 1977, when they were raised after litigation which challenged the low fee levels.

b. Are formularies for drugs being restricted?

California uses a drug formulary. Reimbursement is based on the lower of EAC, MAC or MAIC (the California equivalent of MAC). The dispensing fee is set at $3.06 and has been unchanged in approximately 1-1/2 years. MAIC is used to determine reimbursement for approximately 50 out of 600 drugs on the formulary. California is presently operating under a waiver for EAC reimbursement.

Drugs for chronic illnesses are subject to minimum quantity requirements. For approximately 30 drugs, 100 units dosage must be provided. Other maintenance drugs are subject to frequency of billing requirements and cannot be filled more than 3 times in any 75-day period. Exceptions apply to the initial prescription and where prior authorization is obtained.

Certain drugs in the formulary are described as code-1. These drugs require prior authorization unless utilized for specific conditions. Methylphenidate HCL (Ritalin), for example, is restricted for use in minimal brain dysfunction in children. Other uses require prior authorization.

Certain over-the-counter drugs are covered. Aspirin and other non-legend analgesic preparations are excluded except for those specifically listed in the drug formulary. Laxatives may be approved with prior authorization. Vitamin combinations are not covered for persons over 5 years of age.

A number of proposals are being considered for changes in the California prescription drug program. (See California-9.) One proposal would require diagnostic documentation for all code-1 drugs on the prescription. Another proposal would delete prescription antihistamines from the program. Another proposal would delete most prescription cough/cold drugs from the program except for dextro-methorphan. Other proposals include deleting hypnotics and sedatives from the program (except chloral hydrate and phenobarbital and adding dalmane), deleting bladder irrigating solutions which are provided by nursing facilities as routine nursing care supplies,

deleting a few miscellaneous OTC drugs from the program (such as zinc ointment), and revising the payment method for OTC drugs.

California does utilize a lock-in for beneficiaries considered to be abusing the program. Presently, there are only 70 "restricted service recipients" on the program. After implementation of MMIS, it is estimated that this will grow eventually to 15,000 beneficiaries. This is out of the 2-1/2 million beneficiaries on the program.

Drugs had been limited to 2 prescriptions per month unless prior authorization was obtained. Now, unlimited prescription drugs are theoretically available.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

    a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

California has a broad program of Medicaid services for non-federally eligible beneficiaries. This program is described as the medically indigent adult program. Effective July 1, 1976, resource and income criteria were changed for the MIA program to coincide with medically needy criteria. This was a product of a task force report. Costs, however, have been higher than expected from this change.

Effective July 1, 1976, the state also shifted to a 1-year recertification of eligibility for MIA beneficiaries. Prior to this time a 1-month period was used. Income exemptions are still somewhat different between the medically needy and the medically indigent. The medically indigent exemptions track AFDC requirements, while the medically needy program utilizes SSI rules.

In fiscal year 1976-1977, expenditures for the medically indigent totalled $325,824,412.

    b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to the medically indigent adult program, counties in California operate approximately 30 county hospitals and numerous public clinics. These hospitals and clinics continue to be a primary source of care for many Medicaid recipients and non-Medicaid eligibles. California has a strong local responsibility requirement.

The future of public facilities in California, however, is very much in doubt because of the fiscal crisis precipitated by Proposition 13. Reductions in county hospital services have been initiated in many counties as a result of legislation enacted in the wake of Proposition 13 in July. In fiscal year 1976-1977, unreimbursed county expenses for operating the county public health system totalled approximately $550 million.

COLORADO

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

a. Are states changing income criteria?

Colorado revises its income criteria yearly effective July 1. On July 1, 1978, SSI standards for the blind and disabled were increased from $195 to $206; standards for the aged were increased from $215 to $229. Colorado does not utilize SSI income disregards in determining eligibility for its state supplement program. As a result, although everyone who gets a state supplement gets Medicaid, not everyone who gets Medicaid gets a state supplement.

SSI, for example, provides a $20 unearned income disregard. This is not provided for the optional supplement program. Thus, an individual who has $208 per month from Social Security Title II benefits would be eligible for the $20 income disregard in computing SSI eligibility. Since $188 ($208 minus $20) is less than the federal SSI standard of $189.40, such an individual would receive a $1.40 SSI benefit plus Medicaid. Such an individual would not receive a state supplement, however, since his/her income of $208 per month exceeds the state benefit level of $206. The aged and disabled are limited to a $50 earned income disregard ($20 plus one half of the remainder up to $30), while the blind receive an earned income disregard of $85 plus one-half.

b. Are states changing resource criteria?

The staff indicated that an attempt is being made to raise the resource criteria through the State Board of Social Services. Presently, resources are set at $1,000 for an individual or $1,500 for a couple. The equity value of a car is included within this personal property limitation. A home occupied by the applicant or recipient is exempt.

Colorado has a transfer of property prohibition contained in Colorado Revised Statutes (1973) §26-2-111(1)(c). This provision prohibits transfers for the purpose of gaining or maintaining eligibility for less than fair market value within five years prior to the month of application. A rebuttable presumption is created. In

the event of a property transfer, the excess value of the property is pro-rated for an indefinite period based on the need standard applicable to that size family.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Colorado provides Medicaid for the following subclass of Ribicoff children: (1) children for whom public agencies are assuming full or partial financial responsibility and who are in foster homes or in private child-caring institutions; (2) children in intermediate care facilities; and (3) children receiving active treatment in psychiatric hospitals.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are included in the Colorado Medicaid program and in the state AFDC program. Eligibility, however, is on a limited basis in recognizing the needs of the unborn. Thus, a woman pregnant with her first child would be treated as a one family budget unit with $4.00 additional for the needs of the unborn child.

e. What is status of coverage of AFDC-UF families?

The state covers AFDC-UF families based on the federal definition.

f. Are states proposing changes in operation of spenddown?

Colorado underwent a major change in the operation of its spenddown program. Until earlier this year, Colorado "masqueraded" as a 209(b) state. This was accomplished by allowing aged, blind, and disabled individuals to spenddown to state supplement level. The staff indicated that at any one time approximately 250 people were on this spenddown program. Colorado had thereby attempted to accomplish a medically needy program for only the aged, blind and disabled. The staff expressed their desire to see an authorization for reasonable classifications of medically needy individuals.

g. What are states doing with regard to 209(b) option?

Colorado has never been a 209(b) state and is not interested in becoming one due to the administrative

costs present. It often is described as a 209(b) state, however, due to the unusual spenddown program that it had until recently.

2. Compare use and operation of spenddown provision among states.

   a. Are states changing income lines or operation of spenddown?

Colorado no longer has a spenddown program.

   b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

When a spenddown program existed, a 6-month accounting period was used.

   c. What groups use the spenddown provision? How is public informed about spenddown provision?

When the spenddown program was in existence, individuals generally found out in one of two ways. Individuals who applied for welfare assistance and who were marginally ineligible due to excess income were informed of the spenddown program. Other individuals learned of its existence through institutional providers.

   d. How is spenddown administered?

Colorado has no spenddown program.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

   a. What limits are being considered on amount of service?

Colorado had proposed a prudent buyer experiment for inpatient hospital services. This program would have required a section 1115 waiver. No waiver was granted. The staff indicated that increased pressure will be placed on attempting to gain a waiver once a presently-pending hospital lawsuit over reimbursement rates is settled.

Up until 1974, Medicaid recipients were limited to 12 physician visits per year. The trend in the Colorado

program is away from such arbitrary limits. Home health services are limited to 150 visits per year. Services of 1 to 4 hours constitute a visit.

b. What changes are anticipated in coverage of optional services?

The staff indicated that major changes are not anticipated in coverage of optional services. Second opinions for surgery will likely be added. The staff indicated that this was more to please HEW than for any internal reasons since they believed that the PSRO discourages unnecessary surgery.

No rural health clinics have been certified for Medicaid in Colorado. State law has been interpreted as not permitting practice by physician extenders, even as ancillary to physician services. A recent A.G. opinion has indicated that physician extenders, could practice if the physician was willing to assume responsibility for indirect supervision. Staff indicated that fiscal concerns have limited development of the program.

c. Are copayments being imposed? If so, at what level and on what services.

Copayments are not presently being imposed in the Colorado program. A copayment of $.50 on prescription drugs is expected, however. It has already been taken to the Medical Care Advisory Committee. The exact shape of the copayment program is unclear.

The staff indicated a desire to not increase administrative burdens. They indicated that over-utilization was felt to be a problem, especially at the nursing home level. One approach that was discussed in lieu of a copayment was to use a punch card which indicated physician visits and prescription drugs as a utilization control mechanism. The hope was expressed that providers would identify problem situations and counsel offending recipients. A lock-in is not utilized because of administrative difficulties.

d. Is prior authorization being imposed?

Prior authorization applies to durable medical equipment and EPSDT dental services. Where durable medical equipment is indicated, the physician submits a form to Blue Cross-Blue Shield for review. The Blues administer a separate contract for review of dental services.

Although an appeal mechanism exists for both providers and patients, it is seldom used. The beneficiary receives no notice of the denial on a prior authorization request, and therefore no notification of his/her fair hearing rights.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

   a. Are physician fees being limited?

Physician fees are based on the Colorado 1968 RVS with some updating. However, the conversion factor has been unchanged since 1974. Attempts to raise the conversion factor for the last 2 years have been unsuccessful. In a survey conducted 1-1/2 years ago, only 50 per cent of practicing physicians participated in the Colorado Medicaid program. Since fees have been frozen since 1974, the staff indicated that participation rates are now probably much lower.

   b. Are formularies for drugs being restricted?

Colorado uses a drug formulary of approximately 4,000 drugs. Three types of drugs require prior authorization: amphetamines for hyperkinetic children or in cases of narcolepsy, vitamins, and drugs not listed on the formulary. Obesity treatment is not covered under the Colorado program. Over-the-counter drugs except for aspirin, and insulin are also not covered unless prior authorization is obtained.

Dispensing fees for pharmacies were updated effective July, 1977, from $2.00 to $2.50 for retail pharmacies, and from $.95 to $1.20 for institutional pharmacies. The government pharmacies receive no dispensing fees. These fees are being reevaluated now. The staff indicated that approximately 96 per cent of retail pharmacies participate in the program.

No particular form is used for prior authorization requests for prescription drugs. A physician writes a letter describing the diagnosis, the prognosis, and the drugs he/she wishes to use. There is some telephone prior authorization, and, in emergencies, there can be retroactive prior authorization. The staff indicated a one week turnaround time.

Maintenance drugs must be dispensed in a 30-day supply or in dosages of 100. Insulin may be dispensed in from 4

vials to a 30-day supply. There is some talk of changing procedures for handling drugs like Valium. One thought is to place a maximum number of prescriptions of this type per month with the possibility of prior authorization above this level. Another possibility is putting this entire class of drugs on prior authorization.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

    a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

The major source of medical care for non-Medicaid eligibles is the medically indigent program. This program is approximately 4 years old. Colorado General, a publicly funded hospital, had established an "ability to pay" scale based on income but without consideration of medical expenses. This scale was then used to determine eligibility for hospitals participating in the medically indigent program. About 5 hospitals presently participate.

Each hospital administers an ability to pay scale, keeps track of services rendered, and cost-settles with the state each quarter. Reimbursement is based on a pro-rata portion of the state allocation with each Hill-Burton facility receiving a 3 per cent reduction in reimbursement. This reduction is an attempt to recognize the Hill-Burton charity care obligation. Presently, hospitals get about 50 per cent of costs. Nine million dollars were appropriated under the program last fiscal year; $10 million dollars were appropriated this year.

This year, services were opened to private non-profit hospitals instead of merely public district hospitals. Approximately 13 hospitals are expected to participate this year. Last year 12 district or public hospitals were funded by the state or through public sources. Of these 12, 5 participated in the medically indigent program. Denver General Hospital was by far the most significant.

One other change in the 1978-79 fiscal year was an allocation of $100,000 to pay for physician services and hospitals. This will almost certainly be reimbursed in conjunction with inpatient services.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to the medically indigent program, adults receive services through the 12 district or public hospitals. To a large extent, these hospitals are administered really as private non-profit facilities. The staff estimated that 70,000 individuals below the poverty level are not receiving Medicaid in Colorado.

DELAWARE

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Delaware only provides optional supplements to individuals in adult foster care. The supplemented benefit level for such individuals was $265. Effective July 1, 1978, this was increased by 6.5 per cent. This represents a pass-on of the federal cost-of-living increase and the same cost-of-living increase on the state share.

Delaware last increased its AFDC grants in 1974. A need standard was established in 1968. Delaware had used a ratable reduction. This ratable reduction was increased each year until 1974 when it was increased to 100 per cent. Delaware AFDC grants are therefore equal to 100 per cent of the 1968 need standard. (Grant levels are set forth in Delaware-1.)

   b. Are states changing resource criteria?

Delaware exempts a home and car under its AFDC program. Non-exempt property must be worth less than one month's grant. No changes in resource limitations are expected.

A transfer of asset prohibition is applied to AFDC recipients and applicants. This is based on a state statute which imposes a 2-year disqualification for any individual who transfers property for less than fair market value within 2 years of applying for aid or while on aid. There is no intent requirement. The staff indicated that in some circumstances, however, the state does provide assistance to the family anyway, but the needs of the offending parent are excluded.

In the situation in which one spouse becomes institutionalized, Delaware continues to exempt a home if occupied by a needy relative. Relative is not limited to spouse or child.

   c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Medicaid is provided to financially eligible individuals under the age of 21 for whom public agencies are assuming full or partial responsibility in foster homes or private child-caring institutions. The staff indicated that the state had attempted to get general assistance children included as "Ribicoff children." This was not accepted as a reasonable classification by HEW. The state is continuing to press for federal matching for this group, however.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are covered for AFDC and Medicaid at the beginning of the ninth month of pregnancy. The unborn is treated as an additional member of the family budget unit. Thus, a woman pregnant with her first child would be treated as a family budget unit of two. The staff indicated that although coverage begins with the ninth month, pre-natal care is generally available since the package price for a delivery includes pre-natal care.

e. What is status of coverage of AFDC-UF families?

Delaware provides AFDC and Medicaid for families with unemployed fathers based on the federal definition of unemployment.

f. Are states proposing changes in operation of spenddown?

Delaware does not have a spenddown. The staff indicated that there has never been any real consideration of establishing a medically needy program. In fact, Delaware does not even provide the optional categorically needy program for individuals in long-term care who have incomes less than 300 per cent of the federal SSI benefit. Thus, an individual in a long-term care facility must be eligible for AFDC, SSI or state supplementary payments if they left the facility in order to be eligible for Medicaid. If an individual is so eligible, a 1-month accounting period is used to determine spenddown. There is one exception to this. In state institutions, a quarterly accounting period is used.

g. What are states doing with regard to 209(b) option?

Delaware is a 1634 state and has never considered the 209(b) option?

2. Compare use and operation of spenddown provision among states.

Delaware does not have a spenddown program for either the medically needy or under section 209(b).

3. Identify and analyze current potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

Inpatient psychiatric care is limited to 21 days. Obesity treatment is limited to 1 visit in the individual's lifetime. Outpatient psychiatric care is also limited to 1 visit in the person's lifetime. Eyeglasses and examinations for children (there is no adult vision care program) is limited to once per year unless additional services are medically necessary.

EPSDT services generally must be obtained from the Division of Public Health. Although there are a few other institutional providers, Delaware has established a capitated fee schedule for services like dental care ($73 per child). As a result, most dental care for children must be obtained through the Division of Public Health. Other limits under the program are described in the excerpt from the Provider Manual entitled Program Benefits (included as Delaware-2).

b. What changes are anticipated in coverage of optional services?

The staff indicated that the state is thinking about including personal care services to diminish the need for long-term care. Less likely expansions would be the coverage of GA children and psychologist services in clinics. There is no physician extender law in Delaware and therefore no rural health clinic program.

c. Are copayments being imposed? If so, at what level and on what services?

No copayments are imposed under the Delaware Medicaid program and none are being considered.

d. Is prior authorization being imposed?

Prior authorization is imposed on some drugs, on long-term care placements, on out-of-state care, on all eyeglasses and examinations for children, on dental care for children which cannot be provided through the Division of Public Health, and on some non-emergency medical transportation. Vision care services are prior authorized in order to insure that a recipient has not exhausted his/her limit. Thus, a provider will not get stuck for a bill.

Non-emergency medical transportation is usually prior authorized through a local office and provided through the Delaware Authority for Medical Transportation (a state agency). All other services are prior authorized through the central office. The staff indicated that the turnaround time varies considerably and noted a problem in getting adequate medical verification. The beneficiary is not notified unless it is the beneficiary who made the request for prior authorization. (A copy of the prior authorization request form is included as Delaware-3.)

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

   a. Are physician fees being limited?

Physician fees are based on the lesser of the 75th percentile of usual and customary charges based on 1976 profiles, on actual charges, or on a statewide fee schedule. New providers are limited to the 50th percentile of usual and customary charges. These are providers in their first year of practice.

CPT-4 codes are used for establishing fees. The statewide fee schedule is based largely on 1976 profiles.

   b. Are formularies for drugs being restricted?

Delaware does not use a formulary for prescription drugs. There are some exclusions, however. Anorexants, for example, are limited to the treatment of narcolepsy and hyperkinesis. Other excluded drugs are subject to prior authorization by consultants in the drug program.

Reimbursement is based on MAC and actual acquisition costs (AAC). AAC is determined by surveying wholesalers' prices. A computer edit is then established and invoices over the pre-determined screen are audited to

verify acquisition costs. Effective July 1, 1978, the dispensing fee was increased from $2.00 to $2.50. This was effected by the legislature after a pharmaceutical boycott of the program in late June. The legislature passed the new fee as an urgency statute and mandated a survey to be determined to establish dispensing fees. This should be completed in November.

Over-the-counter drugs are limited to pediatric vitamins, insulin, and insulin supplies.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

   a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Delaware has a program of general assistance for families with children not covered under the state's AFDC program. Also included are single individuals between the ages of 18 and 54 who are unemployable, single individuals over the age of 54, pending SSI applicants, and childless couples where one of the individuals is unemployable.

General assistance is administered on a statewide basis. There is no county responsibility. There is also no medical care vendor component to the GA program. Medical services must be obtained through the Division of Public Health. The staff indicated that 10,000 individuals were aided during the past fiscal year. That is an unduplicated count. No figures were available on the cost of medical care. (GA eligibility standards are included as Delaware-4.)

   b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to the Division of Public Health, the State operates Delaware State Hospital for psychiatric care, the Hospital for the Mentally Retarded (an ICF-MR), the Delaware Hospital for the Chronically Ill (an ICF), E.P. Bissell Hospital (a hospital and ICF facility), and Governor Bacon (an ICF). Even in these facilities, most of the beds are Medicaid beds. Due to the extremely limited coverage of long-term care in the Delaware Medicaid program, many individuals who would otherwise be institutionalized must remain at home.

FLORIDA

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Florida provides optional SSI supplements to only 2 very limited classes of recipients--individuals in adult foster care or room and board situations. As a result, income criteria for SSI recipients increased by the amount of the federal cost-of-living increase effective July 1, 1978.

AFDC benefits are based on a consolidated need standard with a ratable reduction. The consolidated need standard was last updated in 1973. The ratable reduction was increased effective July 1, 1978 from 83 to 85 per cent.

   b. Are states changing resource criteria?

Resource limits for an individual under the AFDC program are $600 for a child living with independent relatives, and $1,200 for a family group. In addition, Florida exempts the homestead.

There is no transfer prohibition presently being enforced in the Florida Medicaid program although the legislature enacted a 2-year prohibition. Earlier, Florida had a transfer prohibition that created an irrebuttable presumption. This was enjoined by a District Court. A new rule was enacted establishing a rebuttable presumption. This has not been implemented, however, because it applies to all aid categories and appeared to violate the earlier court order.

The staff indicated that the department is presently awaiting an opinion of the Attorney General regarding enforcement. There is strong pressure from the legislature to implement this provision. An individual who transferred property for less than fair market value would be subject to a flat 2-year disqualification.

In a situation in which one spouse becomes institutionalized, Florida continues to exempt the house if the individual is likely to return home (for an indefinite period), or if the home is occupied by a spouse or dependent child.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Florida provides Medicaid for the following subclass of financially eligible individuals under the age of 21: all children for whom public agencies are assuming full or partial financial responsibility, and who are in foster homes or private child-caring institutions. The staff indicated that no expansion of coverage is expected.

d. Are unborn children covered? Are there plans to change such coverage?

Effective July 1, 1978, Florida began providing direct cash assistance and Medicaid to families with unborn children. A pregnant mother is treated as a family budget unit of one. The Atlanta Regional Office has refused to approve the Florida state plan, indicating that the needs of the unborn child must be recognized.

The staff expressed some concern over continued funding for the program, at least at a cash assistance level, due to the uncertainty of continued federal financial participation. At present, both cash assistance and Medicaid begin upon medical verification of pregnancy.

e. What is status of coverage of AFDC-UF families?

Families with unemployed fathers are not covered under either the state AFDC or Medicaid plans. The staff indicated that there was no likelihood of coverage since there was a general concern that the program encouraged unemployment.

f. Are States proposing changes in operation of spenddown?

Florida has no spenddown program.

g. What are states doing with regard to 209(b) option?

Florida is a 1634 state. They never seriously considered the 209(b) option, despite displeasure with a number of SSI provisions. These were primarily the lack of a transfer prohibition, dissatisfaction with the holding-out regulations, the inclusion of cemetery plots as resources, and the inadequacy of the SDX tapes as to timing and accuracy.

2. Compare use and operation of spenddown provision among states.

There is no spenddown program in Florida except for the nursing home cap. The cap is set at $515, and is generally increased each year. It is not at 300 per cent and has not been since the initial year. A 1-month accounting period is used. Families are generally informed of the availability of this program by the nursing home.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

   a. What limits are being considered on amount of service?

A variety of limits are imposed under the Florida Medicaid program. Inpatient services are limited to 45 days per year. Outpatient services are limited to $100. With approval for emergency situations, this can be extended to $200. Effective October 1, 1978, this limit is being increased to $500 although no exceptions will be provided.

Lab and x-ray services are limited to $50 per fiscal year with exceptions for extenuating circumstances. Drugs are limited to $22 per individual per year or $33 per institutionalized recipient. Prior authorization is available for additional medication with medical necessity. (A summary of the scope of services is included as Florida-1.)

   b. What changes are anticipated in coverage of optional services?

Probably the major change is in the coverage of mandatory services. A new pilot project was created by the legislature called the "Hospital Outpatient Services Pilot Project." This project resulted in the increase in coverage of services from $100 to $500.

Under the program, counties or local agencies which have been spending money on outpatient hospital services (there are 17 of these) agree to pledge a dollar amount based on their previous expenditures for these services. These 17 counties contain a large percentage of the Medicaid population of the State. The counties agree to pay 50 per cent of the cost of care not to exceed their previous year's expenditures. Since the federal government reimburses Florida for approximately 57 per cent of expenses, leaving a state share of approximately 43 per cent, there is a 7 per cent increment available (50 per cent minus 43 per cent). This 7 per cent is used to pay for expanded services in counties

which did not have any expenditures for outpatient hospital services (approximately 50 counties), services in out-of-state hospitals and the project's administrative costs. No state dollars are provided under the program. Thus, if county participation is inadequate, the project will end.

The expectation is that even if the county share is increased to 60 per cent, which the staff indicated is a likely possibility, the major counties will still come out ahead under this program. This pilot project is an outgrowth of an effort to better utilize county funds currently being spent on Medical care for Medicaid recipients. The pilot project will be implemented effective October 1, 1978.

Effective August, 1978, nurse-midwife services were added to the program. The state plan for rural health clinic services has not yet been approved. The state will be reimbursing services based on the Medicare rate for Medicare-covered services plus reimbursement for other services at current Medicaid rates. There are 9 certified clinics under the Medicare program. One problem that has so far barred approval is a lack of authority for retroactive reimbursement under state law. Cost-settling is therefore not possible. The staff indicated that this is the main issue holding up state plan approval.

Increased rates are expected for home health services. Home health agencies must be Title XVIII-approved. One problem was that the state was not providing for equipment and supplies. The legislature recently authorized $1.2 million dollars for durable medical equipment. This is being implemented. In addition, home health services for Medicare/Medicaid recipients were limited to 100 visits per year. This is also now being revised.

c. Are copayments being imposed? If so, at what level and on what services?

The state had imposed a copayment of $.50 on prescription drugs. This ceased in April, 1978 as a result of litigation. There is no present intention to reinstitute copayments.

d. Is prior authorization being imposed?

Prior authorization applies to prescription drugs beyond the stated limits, physician services beyond 3 visits per month, EPSDT dental services beyond $125, EPSDT eyeglasses beyond 1 pair per year, non-emergency medical transportation, and long-term care placements. Medical transportation and long-term care authorizations are completed in the district office. Other prior authorization requests are submitted to the utilization review staff in Tallahassee or to the program development staff in Tallahassee. The staff indicated a turnaround time of 3 to 4 days. The beneficiary is not notified of action on the claim, nor of his/her rights to a hearing.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physicians are reimbursed under 2 different systems. Surgical procedures are based on the Florida RVS with the unit value multiplied by a conversion factor. Effective January 1, 1978, Florida converted from the 1971 RVS to the 1975 RVS. The conversion factor was adjusted, however, so that reimbursement for procedures would remain the same. The staff indicated that physician reimbursement for surgical procedures has not changed since 1971.

Ambulatory services are reimbursed based on the lower of usual and customary charges or a Medicaid fee schedule. Generally, the Medicaid fee schedule is the basis of reimbursement. The schedule was established in 1976 based on statewide fees. Effective January 1, 1978, a 5 per cent reduction in fees was imposed under the program. Thus, fees have not increased since at least 1976, but the staff indicated that they were at these levels much earlier.

Approximately 60 per cent of the active physicians in the state treat at least 1 Medicaid patient per year, but the active participation is far lower. The legislature has directed a review commission to study this problem. Changes have been handicapped by an unwillingness by the legislature to authorize any further expenditures.

b. Are formularies for drugs being restricted?

Florida does not use a formulary and reimburses only for most legend drugs and insulin. Birth control drugs are not covered under the Medicaid program and are only included through family planning suppliers. Amphetamines are also not covered except for other than weight control therapy. MAC and EAC pricing is used with a dispensing fee of $2.75 (up from $2.40 effective July 1, 1978). The only non-legend drug which is covered under the program is insulin. No other drugs can be authorized. A lock-in is used to restrict beneficiaries to a single pharmacy.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Florida does not have a state program of medical care for non-Medicaid eligibles with 100 per cent state funding.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

Some counties have general assistance programs that provide some medical assistance as a component to that program. Some counties also operate public hospitals. Data on actual county expenditures is extremely weak. Counties were spending at least $3.5 million for outpatient hospital services in unreimbursed funds. In addition, some counties have arrangements with private hospitals for reimbursement.

The staff indicated that there is a serious problem in the state with getting coverage for delivery of children. Many counties have no service facilities, and the staff indicated that the state is exploring ways of trying to prove access to OB/GYN services.

The state had discussed the possibility of using county dollars as a match to establish a medically needy program. This was pretty well abandoned after the staff presented a position paper (Florida-2) on what implementation of such a program would cost.

HAWAII

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Hawaii provides optional supplements for SSI recipients. Effective July 1, 1978, Hawaii passed on only the cost-of-living increase on the federal share. The Hawaii legislature had authorized a cost-of-living increase for SSI beneficiaries, but the cost-of-living increase on the federal share more than exceeded this amount.

AFDC benefit levels were increased by 5 per cent effective July 1, 1978. Medically needy levels for family budget units of 1, 2, 3, and 4 persons were not increased at all. Family budget units of 5 and up were increased by varying amounts to bring them up to 100 per cent of the AFDC need standard for that size family.

Hawaii will be setting their medically needy levels at 100 per cent of the AFDC payment standard. Due to the legislated cost-of-living increase, it was discovered that for large families, the medically needy levels were less than the AFDC levels in violation of federal law. Medically needy levels for small size families were not increased because they already exceed the increased AFDC payment standard.

Income standards are included as Hawaii-1.

   b. Are states changing resource criteria?

Hawaii is a 209(b) state. Hawaii originally became a 209(b) state because SSI resource standards far exceeded the then-Hawaii adult aid resource standards. At that time, Hawaii resource standards were $300 for an individual and $400 for a couple. These resource criteria have been increased over the past few years to the point that they now equal SSI resource standards except in two areas. The first concerns the value of a home. Hawaii limits the maximum value of a home to $40,000 equity. Second, Hawaii considers the cash surrender value of all life insurance as a resource subject to the limitation on liquid resources.

AFDC resource standards also limit a family to $40,000 equity in a home. A car cannot exceed $400, but this

requirement may be waived if the car is necessary for medical reasons, for employment, for marketing, or to take children to school.

The staff indicated that there is at least some thought about exempting a home completely, since this works hardship on needy families, especially in the medically needy program. For the medically needy, 209(b) standards are used.

There is no transfer of asset prohibition in the Hawaii state plan for Medicaid. Legislation has been introduced the past 2 years in the legislature to establish a 5-year prohibition. This legislation has not been widely supported, however.

In the situation in which a spouse becomes institutionalized, Hawaii continues to treat the family as an AFDC unit with both spouses getting a $40,000 property exemption. Thus, if the home is worth less than $80,000, it continues to be exempted for an indefinite period.

c. "Is "Ribicoff children" option being used for some specific groups of children or all children?

Hawaii provides Medicaid for all financially eligible individuals under the age of 21 except those receiving active treatment in a psychiatric hospital.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are included in both the state AFDC and Medicaid plans. Eligibility begins upon medical verification of pregnancy, but a pregnant mother is treated as a family budget unit of only 1 person. The staff indicated that pregnancy nutritional supplements were incorporated in the averaging process when the state went to a flat grant system. The state is presently being sued for a lack of food supplements as a service under the Medicaid program.

e. What is status of coverage of AFDC-UF families?

Hawaii provides AFDC and Medicaid to families with unemployed fathers based on the federal definition of unemployment. Non-federal eligibles may be eligible under the state general assistance program.

f. Are states proposing changes in operation of spenddown?

Major changes are being made in the Hawaii spenddown program because it is presently out of compliance with federal law. At present, liability is computed, but this liability is not linked to specific medical expenses. As a result, there is no way presently to track medical expenses to determine when the liability is met.

The only time that this is not true is with an institutional provider. With a spenddown eligible, liability for institutional services is assigned to a specific institutional provider.

The present lack of an ability to track outpatient bills therefore depends on a double honor system. It assumes first that the beneficiary actually incurs medical expenses equal to the liability. Second, it assumes that the provider reflects these recipient expenses in the bills to the state.

The state is setting up a spenddown program based on a quarterly accounting period. The beneficiary will be notified of the liability, told to bring in bills, and these bills will be tracked to ensure that a provider does not receive reimbursement for a bill which is to be paid by the beneficiary. The staff indicated that they expect the revised spenddown program to be operational in December.

g. What are states doing with regard to 209(b) option?

As indicated, Hawaii is a 209(b) state. Due to changes in state resource standards, criteria are nearly the same as for the SSI program. The staff indicated that part of the reason for maintaining the 209(b) option was to require beneficiaries to apply separately for Medicaid. With a possible expansion of the home exemption, it is possible that Hawaii would become a 1634 state. At present, however, there are a substantial number of individuals on SSI who are not on Medicaid. The staff indicated that this is viewed as the trade-off for the state administrative costs implicit in the 209(b) option.

2. Compare use and operation of spenddown provision among states.

a. Are states changing income lines or operation of spenddown?

As indicated previously, Hawaii has increased its income lines to reflect changes in the cost of living and has begun changes in the operation of the spenddown program.

b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

The spenddown provision under the 209(b) option is the same as the medically needy program. Both will be revised in the near future.

c. What groups use the spenddown provision? How is public informed about spenddown provision?

A breakdown of the groups using the spenddown indicates that it is overwhelmingly aged individuals in nursing homes who qualify under the spenddown provision. (See Hawaii-2.) In most cases, the institution advises the beneficiary or the beneficiary's relatives to apply for coverage under the spenddown provision.

d. How is spenddown administered?

As indicated, Hawaii is attempting to bring their program into compliance with federal law. A 3-month accounting period will be utilized and calculations will be done manually.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

The Hawaii Medicaid program operates on a open-ended budget at the state as well as the federal level. This past fiscal year a $13 million supplemental appropriation was needed. As part of this process, the state administrator was required to make a shopping list for the legislature of possible cuts. The staff indicated that there will probably be no immediate changes, but the state legislature is reaching the limit of funding for the program. At present there are no absolute limits on services. (A copy of these cost-containment measures is included as Hawaii-3.)

b. What changes are anticipated in coverage of optional services?

Coverage of rural health clinics is uncertain at this time pending an attorney general's opinion construing the state physician extender law. No major changes are anticipated in coverage of optional services. There is no coverage of transsexual surgery, although the state lost both cases in which they denied reimbursement for transsexual surgery. Home health services may be provided through any Title XVIII certified agency based on a doctor's prescription. Most home health services are provided through private agencies.

c. Are copayments being imposed? If so, at what level and on what services?

No copayments are presently being imposed under the Hawaii Medicaid program. The staff indicated that there is some consideration of a $.50 copayment on prescription drugs.

d. Is prior authorization being imposed?

Prior authorization is imposed on a variety of services under the Hawaii plan. Inpatient review is presently being conducted by utilization review committees pending a memorandum of understanding with the Hawaii PSRO. The 50th percentile of PSA-LOS is presently being used with an extension to the 75th percentile.

Among the services subject to prior authorization are lab and x-ray services exceeding $25, long-term care placements, dental services for certain procedures, and non-emergency transportation. Non-emergency transportation is authorized by a local social worker.

Providers initiate prior authorization requests on a Form 1007 (included as Hawaii-4). Claims now go to the fiscal intermediary for review by a registered nurse pursuant to state guidelines. If the request is not routine, or if it is to be denied, then it is sent to the state for review. It is reviewed at the state level by 1 of 2 staff persons. The beneficiary and provider are both notified, the beneficiary on a PW-137 (included as Hawaii-5). The staff indicated that often the beneficiary does not know that the service has even been requested.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physician fees are reimbursed based on 1975 fee profiles. Reimbursement is provided up to the 75th percentile. Each biannium, a budget is submitted based on updated profiles and increased fees, but no increase has been approved by the legislature in the past few years. The staff indicated that there is no present problem with physician participation but that there will be in the near future. Fee profiles are compiled based on a statewide schedule. (A copy of the Provider Manual is included as Hawaii-6.)

b. Are formularies for drugs being restricted?

Hawaii is just developing a formulary which will describe the drugs to be covered and thereby restrict coverage somewhat. Over-the-counter drugs would be eliminated, as included in the flat grant cash assistance payments, except for insulin and insulin supplies. The staff indicated that these steps are viewed as a cost-containment measure in conjunction with an attempt to change the generic drug substitution law in the state. Presently, Hawaii has an anti-generic drug substitution law.

All legend drugs were and will be covered in the formulary, but there will be a strong push for generic prescribing. Food supplements and vitamins (except B vitamins) were and will be excluded.

Hawaii is going to MAC and EAC pricing. Presently, reimbursement is based on 180 per cent of the Blue Book price. The state will be setting a dispensing fee and is in the initial steps of conducting a survey of pharmacy costs.

It is expected that the changes in the drug program will be effective approximately January 1. The staff indicated a desire to have these measures completed before the beginning of the new legislative session.

c. Miscellaneous.

An effort has begun to restrict payment for hospital and other services. This effort is known as the 9 per cent solution. Both institutional and non-institutional providers have been meeting in an attempt to control hospital costs. Task forces are looking at alternatives including a rate-setting commission and prospective rate

setting. The staff indicated that any action is months down the road.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

   a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Hawaii provides services to non-Medicaid eligibles with 100 per cent state funding through a combination of programs. The largest program is the general assistance medical care program. The scope of services is identical to Medicaid. The money payment standard and resource limits are the same as for AFDC.

The legislature recently cut back on this program by excluding individuals and childless couples age 21 to 55 who are employable. This was effective April 25, 1978.

State-only costs for the GA program were $15 million in the last fiscal year. These include state-only medical care payments for general assistance recipients and for spenddown GA-linked eligibles.

Hawaii also has a program of Medical Payments to Pensioners (MPP). This program provides medical care for state or county government retirees with incomes of less than $2,400 per year. These individuals and their families receive free medical care. There is no spenddown possible, but resources are not considered in determining eligibility. The Medicaid scope of services is provided. $190,367 was expended in the last fiscal year. The staff indicated that this is a decreasing population due to the low income limits for the program.

   b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to the foregoing programs, the state operates hospitals, skilled nursing facilities and intermediate care facilities. Applicants must apply for Medicaid, however, in order to maximize state reimbursement. In addition to these programs, the state has a renal dialysis disaster program to fill the gap between Medicaid and Medicare. This program is administered through the Department of Health.

The Department of Health also administers a leprosy program and a tuberculosis and psychiatric hospital program. The staff could not provide information regarding expenditures under these programs since they are not administered by the same agency.

ILLINOIS

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Income criteria are recommended by the director and enacted by the legislature. A 5 per cent increase was enacted effective July 1, 1978. The last previous increase was in October of 1974. (Present income criteria are included as Illinois-1.)

   b. Are states changing resource criteria?

Illinois has a 5-year transfer of asset prohibition. If an asset is unreported, it is presumed to be an improper transfer. This presumption can be rebutted, however. The transfer of asset prohibition applies to the adult aid categories. It has been in state law for many years.

In the situation where one spouse becomes institutionalized, Illinois treats the household as separate units if the institutionalization is not expected to be short-term. Short-term is defined as less than 90 days. In any event, the house continues to be exempted if occupied by a spouse or dependent child.

   c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Illinois provides Medicaid for financially eligible children under the age of 21 for whom either the Illinois Department of Children and Family Services or the Illinois Department of Corrections has accepted supervision or guardianship and financial responsibility.

The staff indicated that the state had wanted to add general assistance recipients under the age of 21 to the Medicaid program, but HEW had concluded that this was not a reasonable classification.

   d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are not included under either the state AFDC or Medicaid program. Thus, a woman pregnant with

her first child has no linking to the Medicaid program for eligibility.

e. What is status of coverage of AFDC-UF families?

Illinois provides AFDC and Medicaid for families with unemployed fathers based on the federal definition.

f. Are states proposing changes in operation of spenddown?

Illinois is currently working with HCFA to bring its spenddown program into conformity with federal law.

g. What are states doing with regard to 209(b) option?

Illinois became a 209(b) state because of a fear of increased numbers of beneficiaries added to the welfare and Medicaid roles. The staff indicated that no change in the 209(b) option is expected.

2. Compare use and operation of spenddown provision among states.

a. Are states changing income lines or operation of spenddown?

As indicated, income criteria for the aged, blind, disabled and families were increased effective July 1, 1978. Medically needy levels are set at 100 per cent of the AFDC standard and were also therefore increased effective July 1, 1978. There is no plan to increase medically needy levels beyond 100 per cent of the AFDC standard.

b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

The medically needy spenddown is administered the same as the 209(b) spenddown.

c. What groups use the spenddown provision? How is public informed about spenddown provision?

The staff indicated that there was no data available on the demographic characteristics of groups using the spenddown program. As in most other states, the public

is informed about the spenddown provision by the institutional provider. (Copies of the State informational pamphlet and HMO flier are included as Illinois-2 and -3, respectively.)

d. How is spenddown administered.

Illinois administers 3 types of spenddown programs. The first is a hospital spenddown. A 6-month accounting is used, and the hospital is advised to collect the determined liability. Presently, there is no system for identifying the bills which were used in satisfying the liability so that this system depends in part on the honesty of the institutional provider. With implementation of MMIS in about 12 months, this safeguard will be included.

The second type of spenddown is the long-term care spenddown. This program also uses a 6-month accounting period, but eligibility is monitored to insure that $25 is maintained by the institutionalized recipient.

The third type of spenddown is the ambulatory care spenddown. A 6-month accounting period is used here as well. The beneficiary sends in the liability amount to the department. A card goes out automatically each month. A reminder notice is sent out if the liability is not paid. In the event that the beneficiary incurs medical expenses in an amount less than the liability, the state refunds the excess of the spenddown liability over the medical expenses.

The staff indicated that they would like to have a 6-month eligibility period with a 1-month accounting period with money paid directly by the beneficiary as a condition of eligibility. They would also like to shift to certification periods like foodstamps where eligibility ceases completely after the end of the certification period. In this way the beneficiary would have to come in and completely reapply. (A copy of the spenddown worksheet is included as Illinois-4.)

3. Identify and analyze current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

Staff indicated that there is no intent to impose new absolute limits on scope of services. These were last seriously considered in late 1971.

b. What changes are anticipated in coverage of optional services?

No changes are anticipated in the coverage of optional services at this time. (Coverage under the program is specifically described in the Handbook for Physicians (Illinois-5), and in the informational releases for Dentists, (Illinois-6), Optometrists (Illinois-7), Podiatrists (Illinois-8), and Chiropractors (Illinois-9).

Two applicants have applied for certification under the Rural Health Clinic Services Act. Home health services are limited to Medicare-certified providers. 132 Medicare-certified home health agencies participate in the state Medicaid program.

c. Are copayments being imposed? If so, at what level and on what services?

No copayments are imposed under the Illinois Medicaid plan and the staff indicated that there is no intent to impose copayments.

d. Is prior authorization being imposed?

A variety of services are subject to prior authorization. Many dental procedures are subject to prior approval by Dental Health Administrative Consultant Services, Inc. (DHACS). DHACS also conducts post-treatment dental reviews to ensure that dental services were provided and were of an acceptable quality, i.e. in keeping with good standards of dental practice.

Hospital stays are subject to PSRO review. Durable medical equipment, certain vision/hearing services, home-health, and various rehabilitation services are subject to prior authorization requirements.

The Department employs various professional consultants in the administration of the prior approval program. The patient-recipient is not notified of a prior authorization denial. Litigation is pending against the Department on this issue.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physician fees were increased effective July 1, 1978 and are based on 1977 charges. Prior to July, 1978, physicians were reimbursed based on the lower of county maximums or state maximums or individual charges. The county and state maximums were based on 1971 fee levels. Now, reimbursement is based on the lower of the amount charged or the state maximum. The state maximum was set at 70 per cent of 1977 average charges. Where this amount is lower than the old state maximum, the old state maximum is used. Provider usual fees are only looked at in audit situations.

Procedures are based on the second edition CPT with additional data being developed by the agency. In 1977, the staff indicated that the state paid 60 per cent of physician charges. A similar procedure is used for all practitioners. Prior to 1978, there had been no increase since July of 1972 when fees were updated using 1971 charge data.

The staff indicated that there are problems with physician participiption, although there is some favorable response to the updating of fees. In addition, the period of time for payment of physician charges has decreased considerably. The state is now processing most claims within 18 to 22 days from submission of a clean bill for payment. The worst period in payment was 1974 when delays of 6 months were common.

b. Are formularies for drugs being restricted?

Illinois uses a formulary for coverage of drugs. Drugs that are not listed in the formulary may be reimbursed with prior authorization. Reimbursement is based on MAC and EAC with a dispensing fee of $2.75 for all types of pharmacies. This fee was increased effective July 1, 1978. It was $2.35 prior to that date. Some uniform minimum amounts are used for maintenance drugs, some maximum dosages are used on other drugs. (The Pharmacy Handbook, including the formulary, is included as Illinois-10.)

c. Miscellaneous.

A rate law has been passed by the Illinois legislature establishing a hospital authority. This hospital authority will set prospective rates.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

   a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Services are provided for non-Medicaid eligibles through a variety of programs. In Chicago and Cicero, the general assistance program is administered by the state. If an individual is cash eligible, then medical assistance eligibility is also established. If an individual is financially ineligible for general assistance then Aid for the Medically Indigent (AMI) is provided. Ten services are provided to such recipients. These include both outpatient and inpatient services.

Outside Chicago there are approximately 1,700 townships. In those that do not get state funds (all but 30 to 50 townships), anything goes. The program is administered through county commissioners or township supervisors. No data is available on the costs in these townships.

In the 30 to 50 townships which seek state funds, the program is the same as in Chicago.

There is therefore wide variation in eligibility and coverage between Chicago and the downstate area. The average GA grant in Chicago, for example, is $228. In the downstate area it is $29. Where the state does participate in costs, 90 per cent of the costs are paid for by the state. The local unit (usually the township) must expend a specified amount before state financial participation is triggered, however. The staff indicated that because of the downstate counties, there is no real pressure for a statewide program.

Illinois also administers an interim assistance program for SSI applicants. If the individual is found eligible, federal reimbursement is claimed under the Medicaid program. If ineligible, the state pays 100 per cent of the costs.

Illinois also administers a migrant medical program. Effective July, 1977, there were only 43 cases.

Applicants apply through the local state offices and are certified for a 3-month period. They receive a limited scope of services. These services include inpatient hospital care; outpatient hospital care; organized clinic care; laboratory services; physicians' services; drugs; family planning supplies and services; emergency dental care (to relieve pain and infection); and medical transportation (to and from the source of medical care).

Illinois also administers an indigent veteran's program.

Cost data was only available for the GA and AMI programs. During the last fiscal year costs in Chicago and Cicero for the GA and AMI programs amounted to approximately $76 million. Outside of Chicago costs amounted to approximately $8.4 million.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to the above programs, there are a number of public hospitals. These hospitals, however, are generally administered like private non-profit facilities and do not have general obligations to provide free care to indigents.

KANSAS

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

a. Are states changing income criteria?

Kansas does not provide optional supplements for SSI recipients. Thus, income criteria for the SSI population last increased on July 1, 1978, by the amount of the federal cost-of-living increase.

AFDC levels were last increased effective July 1, 1976. At that time a 5 per cent increase was implemented. Benefit levels are as follows: (1) $95; (2) $149; (3) $206; (4) $239; (5) $275; (6) $321; (7) $360. In addition, a variable amount ranging from $56 to $125, depending on the size of the family and county of residence, is added on for shelter costs. Thus, a family budget unit of 3 would have a maximum grant of $331 ($206 plus $125).

Medically needy levels have been unchanged since November, 1975. These levels are as follows: (1) $280; (2) $330; (3) $370; (4) $410; (5) $450; (6) $490; (7) $520; (8) $550 with $30 allowed for each additional person. Individuals living in long-term care facilities receive a personal needs allowance of $25.

Benefit levels are proposed by the Department and would be reflected in legislative appropriations. The legislature must approve all regulations of the Department in Kansas. Medically needy levels were set at 110 per cent of the AFDC standard rounded off to the nearest $10. Because the AFDC levels were updated more recently than medically needy levels, the higher protected income level has been narrowed.

b. Are states changing resource criteria?

Resource levels were last increased in March of 1974. A home of unlimited value may be retained, except that if the house is used to produce income, its market value must not exceed $25,000. Other income-producing property may be retained up to $6,000 equity value if it is producing a return of at least 6 per cent of the equity. Non-exempt assets are limited to $1,800 for one person, $2,400 for two, $2,800 for three, $3,200 for four, and

$200 for each additional person. Additional cash assets may not exceed one month's protected income level based on an independent living arrangement. One car of any value is exempt and additional ones if medically necessary or necessary for employment.

Insurance policies with no cash surrender value or of less than $1500 face value are also exempt. In AFDC, both adults and children may have their own policies. Should any family member own policies exceeding $1500, the total cash surrender value of those policies is a non-exempt resource. Some items of property are limited to specific amounts. If an individual has itemized property over that limit, the entire family is ineligible. The excess does not go into a reserve.

The staff emphasized the view that a car of any value should be exempt for every family. The staff stressed the importance of a car in most family situations and the difficulty in administering a system which limits the value of a car. The staff expressed their problems generally with administering three different standards for cash assistance, Medicaid, and food stamps.

There is no transfer of property prohibition in the Kansas Medicaid program. Kansas does have a 5 year transfer of asset prohibition for its state-funded GA medical assistance program. Individuals may not transfer more than $500 for less than fair consideration. Couples or families of more than 2 are limited to $1,000. Thus, for an individual who transfers property for less than fair market value within 5 years of applying for assistance or while on assistance has the first $1,000 exempted. The remaining value is treated as a special spenddown. Thus, an individual or family may be eligible within 5 years of transferring property if medical expenses are incurred in a value in excess of the value of the property transferred.

Where an individual becomes institutionalized, Kansas exempts a home for a 1-year period. The state continues to exempt the home beyond 1 year if it is occupied by a spouse and/or child.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Kansas covers a specific subclass of "Ribicoff children." This class consists of: (1) children for whom public agencies are assuming full or partial responsibility and who are in foster homes, private child-care institutions, or in subsidized adoptions; (2) children in intermediate care facilities; and (3) children receiving active treatment in psychiatric hospitals. As indicated in Question 5, some children

under 21 are aided under the general assistance-medical care program and no financial participation is claimed.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are covered in both the AFDC and Medicaid programs upon medical verification of pregnancy. A mother pregnant with her first child is treated as a 1 person family budget unit. Kansas does have one special feature to its unborn program. An unborn child can be eligible in its own right without providing medical eligibility for the pregnant mother. Thus, if because of parental responsibility a pregnant teenager is ineligible for assistance, Kansas can aid the unborn child. Not all services are provided. Thus, the pregnant mother could not receive eyeglasses since this does not bear directly on the medical needs of the unborn child. Eligibility for the unborn would be computed solely on the income and resources of the pregnant mother.

e. What is status of coverage of AFDC-UF families?

Kansas provides AFDC and Medicaid for families with unemployed fathers. This is based on the federal definition of unemployment. As indicated in Question 5, additional non-federal eligibles can be aided under the GA-medical care program.

f. Are states proposing changes in operation of spenddown?

Kansas is not presently proposing any major changes in the operation of its spenddown program.

g. What are states doing with regard to 209(b) option?

The staff indicated that Kansas was initially a 209(b) state, i.e. attempted to apply more restrictive criteria, although Kansas was never officially listed as such.

Kansas now provides Medicaid for SSI beneficiaries but is not a 1634 state. Instead, the staff indicated that SSI recipients are required to separately apply for Medicaid at a local SRS office. Staff indicated that Kansas is

not a 209(b) state despite the attractiveness of the option because of the administrative burden of separate determinations of eligibility. The staff also expressed a belief that its present transfer prohibition was indistinguishable from those of Missouri and Connecticut which had been invalidated by the courts. They also noted that there have not been many fair hearings on the transfer of asset prohibition. The staff expressed great displeasure over the SSI transfer provisions.

Eligibility standards are set forth in section 5 of the Kansas Medical Assistance Manual (included as Kansas-1).

2. Compare use and operation of spenddown provision among states.

   a. Are states changing income lines or operation of spenddown?

Kansas is not presently changing income lines or operation of the spenddown.

   b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

Kansas is not a 209(b) state.

   c. What groups use the spenddown provision? How is public informed about spenddown provision?

Kansas did not have any information on the groups which use the spenddown provision although it is heavily weighted with aged and disabled individuals. There was no information to identify those medically needy persons who must spenddown in comparison to those who have incomes under the protected income levels. No outreach is done on the availability of the spenddown provision. Instead, most individuals learn about the program through institutional providers.

   d. How is spenddown administered?

Kansas uses a 6-month accounting period for most individuals and a 1-month accounting period in long-term care. Medical expenses are tracked on an SRS 155 form. (A copy of this form is included as Kansas-2.) In long-term care, the provider is notified to collect the additional amount up to the $25 personal needs allowance.

Although a 1-month eligibility and accounting period is used, some district offices were carrying forward excess income to succeeding months. Thus, an individual who had income over the cost of nursing home care in the month of January, but who had income less than the cost of medical care in February, would have his/her liability for the month of February computed including the excess January income. The staff indicated that this is illegal under the state plan and would be modified in the future.

Although a 6-month accounting period is used in most non-long-term care cases, an individual who enters a hospital in January and must enter long-term care in April would have the January through March period recalculated based on a 3-month accounting period.

Kansas uses concurrent month budgeting for its spenddown program. Medicaid cards are actually issued before verification of the incurred expenses in that month. As as result, a Medicaid card may be issued although an individual is technically ineligible.

The staff indicated that the present biggest problem with the spenddown is third party liability. Third party liability expenses are not allowable against the spenddown. The staff indicated it is often difficult to keep track of when expenses are reimbursed by a third party.

In computing the liability, the amount of expenses is based on the state reimbursement level, not on the amount that the applicant or recipient actually is liable for. The Kansas City HEW Regional Office has raised an additional problem with the Kansas plan. They indicated that incurred medical expenses include any expense still owed, whether or not it was incurred in the accounting period. However, this expense can be used only once for computation.

One additional problem related to retroactive coverage. Under present administration, Kansas allows an applicant in April to use medical expenses in January through March and to begin the accounting period in January. The K.C. Regional Office indicated that this is impermissible and that the January through March period must be a separate accounting period.

In a situation where a beneficiary incurs expenses in excess of his/her liability, the beneficiary decides

which expenses will be reimbursed by the state. Reimbursement is not based on a chronological tracking of bills. (See Kansas-2.)

One additional problem raised by staff related to the distinction between covered and non-covered services. The K.C. Regional Office indicated that the State must differentiate between the two in computing liabilities. However, the staff noted that bills from providers do not always indicate enough information to determine whether or not a service is a covered or non-covered service. Uncovered services must be considered first in computing the liability. The staff indicated that these expenses are also limited to a reasonable rate, rather than actual incurred expenses. The Regional Office indicated that once the eligibility base is computed, the state need not re-compute the liability based on additional expenses incurred in the current period.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

   a. What limits are being considered on amount of service?

Kansas has few absolute limits on amount of service and is not considering additional limits. Instead, Kansas relies on 2 types of prepayment review: medical necessity review and prior authorization. Optometric examinations are absolutely limited to once every 2 years (changed from once every 4 years on August 17, 1978) for adults. Even this can be modified in cases of prior authorization. A limitation of one examination every year for children was removed to bring the program into compliance with federal law.

Limits are described in the Service Summary Charts (included as Kansas-3) and in the Physician Provider Manual (included as Kansas-4).

   b. What changes are anticipated in coverage of optional services?

The only change that is being anticipated is a change relating to dentures and eyeglasses. Kansas has not been paying for dentures and eyeglasses for individuals over age 21. This policy was challenged by the HEW Regional Office. The staff indicated that Kansas will pay for dentures and eyeglasses for individuals over age 21 if necessary for employability or to alleviate severe hardship. The Regional Office indicated no problems with

such a standard which does not relate to medical necessity.

c. Are copayments being imposed? If so, at what level and on what services?

Copayments are being imposed on prescription drugs except under EPSDT. Copayments have been imposed since 1975 and the State intends to continue. They are opposed to any change in this requirement on a philosophical basis, acknowledging that there is no data to support the notion that prescription drug copayments are cost-effective.

d. Is prior authorization being imposed?

Prior authorization is being imposed under the program as well as medical necessity review. Medical necessity review is a post-service pre-payment review. Physician office calls, for example, are limited to 3 per month per physician unless supported by written documentation confirming medical necessity. This review is conducted by state consultants who visit the fiscal agent to review pended claims.

Prior authorization review is performed by central office staff in Topeka after the request for authorization is sent to the fiscal agent. (A copy of the request form is included as Kansas-5.) The beneficiary is not notified of action on the request for prior authorization and is not notified of his/her appeal rights.

Those services subject to medical necessity or prior authorization review are described in the attachments prepared by staff for the fiscal agent (included as Kansas-3).

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physician fees were last updated in 1976 based on calendar year 1975 Medicare rates. Office visits are reimbursed at the 75th percentile of usual and customary charges. All other physician services are reimbursed at the 50th percentile of usual and customary charges for 1975.

b. Are formularies for drugs being restricted?

Kansas does not use a drug formulary. Instead, the Kansas Medicaid program covers nearly all legend drugs except those like anorexants which are specifically excluded. (See Kansas Pharmacy Provider Manual, included as Kansas-6, at pp. 14-3, 14-4.)

With prior authorization, an anorexic medication may be approved for hyperkinesis or narcolepsy or in extreme cases for obesity. Many non-legend drugs may also be reimbursed if prescribed by the physician.

Reimbursement is based on federal guidelines plus a variable dispensing fee based on costs. These dispensing fees are updated yearly. For non-legend drugs reimbursement is made on a cost plus markup basis.

Minimum quantities are applicable to a variety of medications including antibiotics, anti-coagulants, and maintenance drugs. Maximum quantities are limited to a 100 day supply.

c. Miscellaneous.

In order to restrict hospital costs, Kansas has limited services permitted in the emergency room to only emergency services; has limited payment for drug and alcohol programs to detoxification unless the hospital has a certified drug and alcohol program approved by SRS; has limited admission between midnight Thursday and midnight Saturday to emergency services, or services on the same day of admission; and has limited psychiatric services to 21 days unless documented longer stays are necessary.

Home health services were limited to 200 visits per 12 months. They are now unlimited but must be provided by a Title XVIII-certified home health agency.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Kansas provides the Medicaid scope of services to a large class of non-Medicaid eligibles under the general assistance-medical care program. Income and resource levels for this program are the same as AFDC. A pro-rata reduction is applied to mixed households, so that a family of 5 living with two other individuals receives

5/7ths of a normal grant and their eligibility for Medicaid is based on that income level. The same income disregards are applied as ADC except a 30-1/3. More liberal real property levels are applied. A home used to produce income may have a market value of $30,000. In addition, general assistance looks at equity rather than market value.

Between July 1, 1978 and September 5, 1978, $2,128,013.84 were spent on the GA medical care population. This annualizes to approximately $11 million dollars.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

The GA medical care program is the primary source of care for medically indigent adults. There are some state hospitals, county nursing homes, and other public facilities.

LOUISIANA

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Louisiana does not supplement federal SSI benefit levels. Thus, SSI benefits increased on July 1, 1978, by the amount of the federal cost-of-living increase. The staff indicated that the state attempts to increase AFDC benefits annually. AFDC benefit levels were increased effective July 1, 1978, retroactive to May 1, 1978, by 4 per cent. Medically needy levels are set at 133-1/3 per cent of AFDC maximum grants and were therefore increased at the same time. (A copy of the medically needy levels is included as Louisiana-1.)

   b. Are states changing resource criteria?

SSI resource levels are used for medically needy individuals. An additional $25 in non-exempt resources is allowed for each additional family budget unit member.

Under AFDC, a house and contiguous property of less than 160 acres in rural areas is allowed. The first car is exempted. This represents a recent change. Until recently a vehicle could not exceed $1,200. Liquid resources cannot exceed $1,000.

Louisiana imposes no transfer of asset prohibition for SSI-linked individuals. A 1-year transfer prohibition exists for AFDC applicants and recipients. The staff described the lack of a transfer prohibition for SSI-linked individuals as bothersome, and felt that SSI should either continue to exempt the home in all cases or not allow transfers. (A copy of the transfer prohibition is included as Louisiana-2.)

In the situation in which a spouse is institutionalized, the state continues to exempt the institutionalized spouse's share of the home if there is a possibility of return. This possibility of return is not limited to a 6-month duration. Instead, a flexible open-ended period exists. If there is no likelihood of return, then the institutionalized individual must transfer his property. In theory this exists even in the case in which the house

continues to be occupied by the dependent spouse or child. New regulations were adopted on July 20, 1978, to guide enforcement of this requirement.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Louisiana covers the following subclass of "Ribicoff children": (1) children for whom public agencies are assuming full or partial responsibility and who are in foster homes or in private child-care institutions, (2) children in intermediate care facilities, and (3) children receiving active treatment in psychiatric hospitals. There is no intention to expand coverage beyond these categories.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are covered under the state AFDC and Medicaid programs at the beginning of the second trimester upon medical verification of pregnancy.

e. What is status of coverage of AFDC-UF families?

Children deprived of parental support or care by reason of the unemployment of the father are not covered in either the state AFDC-UF or Medicaid programs. The staff indicated that coverage was almost established this fiscal year and is possible next fiscal year.

f. Are states proposing changes in operation of spenddown?

Louisiana established a medically needy program effective October 1, 1977. The staff indicated that there may now be some increase in services. ICF care, for example, is not covered.

One problem that was noted related to the coverage of split bills, bills which overlap the establishment of eligibility. Louisiana presently does cover these bills but would like to begin full coverage either with that bill or on the next bill incurred. The staff described the problems with processing such bills by the fiscal intermediary. (The form used in this process is included as Louisiana-3.)

In a situation in which a medically needy individual incurs a charge of $100, the state agency would allow

only the Medicaid reasonable charge of perhaps $80. With a patient liability of $50, the state would only pay $30. The staff indicated that this poses a serious problem with provider relations.

g. What are states doing with regard to 209(b) option?

Louisiana is a 1634 state. It has never been a 209(b) state and never seriously considered it.

2. Compare use and operation of spenddown provision among states.

a. Are states changing income lines or operation of spenddown?

As indicated, Louisiana has increased the income lines for the medically needy program. Louisiana uses a 2-tiered system of protected income levels based on residence in either a rural or urban area.

b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

Louisiana is not a 209(b) state.

c. What groups use the spenddown provision? How is public informed about spenddown provision?

As in most states, the medically needy are predominately aged or disabled. For the period of October 1, 1977 through June 30, 1978, 2,490 individuals qualified under the medically needy program. Of these 1,719 were spenddown and 771 qualified with incomes under the monthly income levels.

When the medically needy program was established in Louisiana, the state conducted outreach in a number of newspapers. (A copy of the press release utilized is included as Louisiana-4.) In most cases, however, potential beneficiaries learn about eligibility through institutional providers. (A copy of the explanatory notice to providers is included as Louisiana-5.)

d. How is spenddown administered?

Louisiana utilizes a 3-month accounting period for determining spenddown liability. This is done on a

flexible basis and initial eligibility may be based on a 1, 2, or 3 month retroactive period in order to maximize eligibility. The staff indicated that a 3-month accounting period was chosen as a compromise measure in order to maximize eligibility while minimizing administrative burden. A 6-month certification period is used for non-spenddown medically needy eligibles.

A spenddown applicant receives a form 110 MNP (Louisiana-3) to list expenditures. Liability is based on actual, not reasonable charges. Louisiana does limit services for which liability can be incurred, however. Services are defined so that only medically necessary services are used by the state to determine spenddown liability. The staff explained that they felt that the definition of services that an individual can spenddown for is too loose.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

    a. What limits are being considered on amount of service?

The state imposes 2 types of limits on scope of services. One type of limit is an absolute cap that may not be waived even in the case of medical necessity. The other is a limit beyond which services can be authorized based on medical necessity.

The first type of limit applies to home health services which are limited to 50 visits per year, and chiropractic services which are limited to 6 visits per calendar year.

Services in the second category include inpatient hospital services. Inpatient hospital services are reviewed pursuant to the PSA-LOS at the 90th percentile. In addition, they are subject to a 15-day maximum with coverage provided beyond that with medical documentation. Since there are no PSROs in Louisiana, this review is done by the utilization review committee of the facility.

Physician services are also limited to 12 outpatient visits per calendar year. A physician desiring additional visits submits a request on a form 158A (included as Louisiana-6) supported by medical diagnosis to the State Medical Director in Baton Rouge. Generally, there is a 2 to 3 day turnaround time. The staff

indicated that physicians are always given at least 1 additional visit since the physician is usually seeing the patient for that additional visit in requesting documentation for prior authorization.

b. What changes are anticipated in coverage of optional services?

No major changes are anticipated in coverage of optional services. The staff indicated that the state is hoping not to impose arbitrary limits. Instead they are focusing on provider education.

The staff indicated some problems with durable medical equipment, especially hearing aids. They are reviewing possibilities for limiting price or may limit coverage to those individuals who need hearing aids in order to gain employability or for educational purposes.

The staff also indicated a problem with outpatient facilities, especially emergency rooms. This problem, the staff indicated, has been compounded by a lack of physician participation. The staff indicated that they would like to see some limit on hospital outpatient services.

As a result of litigation in Pitts v. Stewart, the state is now mandated to provide additional non-emergency medical transportation. An additional appropriation of $2 million was requested from the legislature, but only $833,333 was appropriated. Additional coverage will be implemented effective October 1, 1977 with prior authorization as the main control.

As a result of intervention by the HEW regional office, the state is also expanding coverage by providing dentures for individuals over the age of 21. This service will be implemented effective October 1, 1978 with prior authorization.

The staff indicated that the state hopes to add physical therapy as a home health service next year. In addition, if the PSA-LOS standard proves workable, the state hopes to eliminate the 15-day limitation on inpatient services.

c. Are copayments being imposed? If so, at what level and on what services?

Copayments are not presently being imposed on any service under the Medicaid program. The staff indicated a dislike of copayments since they tend to penalize those most in need.

d. Is prior authorization being imposed?

As indicated, prior authorization is being imposed on a variety of services. These services include: durable medical equipment, extensions on hospital and outpatient visits by physicians, non-emergency transportation, dentures, and some EPSDT services.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Louisiana uses the CPT-4 for procedure codes. Effective October 1, 1978, the state will implement the CPT-4 on the 1974 California RVS using a level 3 conversion. 1975 Medicare screens are presently being used, but effective October 1, 1978, these will be updated to 1977 profiles.

The staff indicated that they liked the idea of a statewide fee schedule instead of 8 regional fee schedules since few rural doctors accept Medicare assignment. This results in low fee schedules in the rural areas. The staff indicated that reimbursement will increase for physicians effective October 1, 1978, and expressed some concern over fiscal effects of this increase.

b. Are formularies for drugs being restricted?

Until the fiscal cutbacks of 1975, Louisiana had an open drug formulary. Presently, there are therapeutic categories for which no coverage exists such as anorexants. Prior authorization is not available for such drugs. In addition, there has been a significant cutback in the availability of non-legend drugs. Those drugs that are covered are reimbursed on a similar system to legend drugs. Non-legend drugs which are covered include insulin, ferro-sulphate preparations (but no vitamins), and calcium. (A copy of the Pharmacy Manual is included as Louisiana-7.)

Louisiana uses MAC and EAC and adds on a dispensing fee of $2.80. This was increased from $2.35 effective July 1, 1978.

The staff indicated that the Dallas Regional Office has been pressuring the state to impose a limit on the number of prescriptions similar to Texas.

c. Miscellaneous.

As indicated, home health services are limited to 50 visits per calendar year and are limited to Title XVIII certified agencies. The state has both profit and non-profit agencies. Until July, 1977, prior authorization was required. Now no prior authorization is required for Medicaid services. The staff indicated that this has resulted in increased expenditures.

There is no state rate commission for hospitals and the Medicare formula is used.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

The state has a program of general assistance medical care coverage. This program includes all services except private hospital services. GA-MC recipients must use the charity hospital system. There are approximately 5,000 individuals on the GA program at present. GA cash levels are set at a higher level than AFDC since eligibility is linked to temporary disability. Expenditures in fiscal year 1977-78 totalled $709,595.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

The main other source of care for medically indigent adults is the charity hospital system. There are 8 charity hospitals in this state as well as Confederate Hospital which is run by Louisiana State University. Eligibility is on a sliding fee scale. Appropriations totalled $28,225,135 in fiscal year 1977-78.

Other sources of care are Title V and Vocational Rehabilitation. The charity hospital system, however, remains the major source of care for medically indigent adults who are not eligible for general assistance.

MAINE

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Maine provides a limited optional supplement for SSI beneficiaries. This is computed in the following manner: The federal benefit level plus the state supplement plus the federal income disregard plus the state income disregard equals the need standard. For independent living arrangements, the state supplement is $10.00 for an individual and $15.00 for a couple. For shared living arrangements, the supplement is $8.00 for an individual and $12.00 for a couple. The state pass-on for an individual is $42.30; for a couple, the pass-on is $64.40.

The need standard for an individual is therefore $261.70 ($189.40 plus $10.00 plus $20.00 plus $42.30). Any individual with income less than $261.70 would therefore be eligible for an optional supplement and for Medicaid. The amount of the optional supplement would be the difference between the need standard and income up to the maximum state supplement. Thus, an individual with $242.00 income would receive the maximum state supplement of $10.00. Different need standards are used for residents of approved foster homes or boarding homes.

AFDC benefits were increased effective September 1, 1977. They will be increased again effective December 1, 1978. AFDC levels are now at 90 per cent of the 1968 need standard. They will be increased to 95 per cent of the 1968 need standard on December 1. The ratable reduction is applied to the need standard before the income is deducted, but the $30 and 1/3 is applied to the full need standard.

Medically needy levels, except for families of 1 person, are set at 133-1/3 per cent of the AFDC standard. They will also, therefore, be increased effective December 1, 1978. The medically needy level for a single person is $210. This will not be increased. The medically needy level for a couple is presently $250 and will increase to $266 effective December 1. (Income levels are included as Maine-1.)

b. Are states changing resource criteria?

The definition of exempt assets is the same under the medically needy and AFDC programs. These are also comparable to the SSI definitions. A home and contiguous land is exempt. A car is exempt. The major difference is with regard to the level of non-exempt assets which may be retained. AFDC non-exempt cash assets are limited to $500 for an individual or $1,000 for a family of 2 or more. Medically needy levels are set at $1,500 for an individual, $2,250 for two, and $100 additional for each additional person.

There is no transfer of assets prohibition in either the AFDC or medically needy programs. In the situation in which one spouse becomes institutionalized, Maine continues to exempt the home. This is accomplished by treating the home as an asset without market value due to the joint ownership interest of the non-institutionalized spouse.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Maine provides Medicaid for all financially eligible individuals under the age of 21. If an individual (and the parents or responsible relatives with whom the individual is living) has income less than the AFDC level, then s/he is characterized as categorically needy. If income is greater than this level, the needy individual would qualify as medically needy. This distinction is only important because the scope of services is slightly more limited for the medically needy.

Coverage was implemented effective in 1974 for "Ribicoff children." This was part of a general expansion of eligibility to include unemployed fathers and the medically needy, as well as the establishment of the state-only catastrophic illness program.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children were deleted from coverage under the state AFDC and Medicaid programs effective April 1, 1975. The staff indicated that this was not based on any ideological considerations, but was only a cost-containment measure.

e. What is status of coverage of AFDC-UF families?

Families with unemployed fathers were eliminated from the Maine AFDC program in 1970 but were included under the Medicaid program effective in 1974.

f. Are states proposing changes in operation of spenddown?

The staff indicated that a variety of changes were being considered in order to make administration of the spenddown program easier. The staff indicated a strong desire to get away from chronological ordering of bills. The state would like to use any bills brought in by the beneficiary in order to satisfy the liability. Instead, the HEW Regional Office has recommended chronological tracking of bills so that liability must be satisfied in the order in which the bills are accrued.

The staff indicated that 2 approaches are being considered. First, the spenddown could be entered into the computer along with the first set of bills credited against the liability. The spenddown eligibles would receive a card documenting eligibility from the beginning of the application period. Obviously, this raises a serious problem with provider relations since a provider would not know whether his/her particular bills would be credited against the liability or would be paid by the department. This might encourage providers to delay their bills in order to be the last submitted.

The second approach being considered would be to disregard chronological tracking and use any bills to satisfy the spenddown. Presently, Maine is performing a straight chronological tracking and is paying for split bills. The staff indicated a lack of interest and direction from HEW in revising their program to make it more workable.

g. What are states doing with regard to 209(b) option?

Maine is a 1634 state and has no interest in the 209(b) option.

2. Compare use and operation of spenddown provision among states.

a. Are states changing income lines or operation of spenddown?

As indicated, income levels have increased under the Maine Medicaid program and will increase again effective December 1, 1978. In addition, there will be some decision on ending chronological tracking within the next few months.

b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

Maine is not a 209(b) state.

c. What groups use the spenddown provision? How is public informed about spenddown provision?

No demographic characteristics were available on the portion of the medically needy population utilizing the spenddown. A new law was enacted effective July 1, 1978, by the Maine Legislature to require an outreach effort by the department. This outreach effort is primarily directed at the Food Stamps population, since this is a group of relatively low-income levels. In addition, the department has made contacts with CAA agencies and has explained eligibility on the program to various provider groups.

d. How is spenddown administered?

Maine uses a 6-month accounting period, with a 1-month accounting period for institutionalized individuals. Instead of treating medically needy eligibility as strict certification periods with a completely new application required, Maine uses an opening date and a review date, not a discontinuance date.

SSI income disregards are applied for SSI-linked individuals; AFDC income disregards are used for AFDC-linked persons. The staff noted a significant problem with using the SSI standards since the Social Security Administration has provided all the guidance of "a stone wall." In addition, the staff indicated that they have received little help from the Medicaid Bureau. This has raised significant problems especially with such SSI requirements as deeming.

As part of the legislation enacted effective July 1, 1978, the department has been directed to determine medically needy eligibility for individuals who are discontinued from cash assistance. This will be limited to the AFDC program since SDX tapes have proven too

inaccurate and contain insufficient information. An AFDC individual who is discontinued will now have eligibility for the medically needy program reviewed.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

   a. What limits are being considered on amount of service?

Few limits are imposed under the Maine Medicaid program. Chiropractic services for acute conditions are limited to 2 visits per week for 1 month. Chronic conditions are limited to 1 visit per week indefinitely. Ambulances will not be reimbursed for transportation beyond the nearest appropriate service location. Psychological services are limited to 1 hour per day, 5 days per week. Coverage was recently expanded for psychiatric inpatient services to 7 days per week. Optometric services include only eyeglasses for adults after eye surgery and only the first pair is covered.

   b. What changes are anticipated in coverage of optional services?

The major recent change in coverage of optional services was the inclusion of intermediate care facilities for the medically needy population effective April 6, 1978. Orthodontia coverage under EPSDT was enacted, after litigation, effective April 15, 1978. Additional coverage is being provided for abortions in outpatient settings. Abortions will still be limited to federal requirements, but access to services may now be improved. These regulations will be going to public hearing soon.

No other changes in coverage of services, either expansions or reductions, are being contemplated.

   c. Are copayments being imposed? If so, at what level and on what services?

No copayments are imposed under the Maine Medicaid program and none are being considered. The staff indicated no support for their imposition.

   d. Is prior authorization being imposed?

Prior authorization is imposed on inpatient hospital services beyond 60 days, long-term care placements, out-of-state services, dental care over $150, durable medical equipment, and some drugs.

Some prior authorization requests are submitted on invoices (see Maine-2); some prior authorization requests are submitted on Form MA-56 (see Maine-3). Most requests are processed in the central office, including eyeglasses and dental. Durable medical equipment requests are usually processed in the regional offices.

Turnaround time had been a serious problem. Effective July 1, 1978, the legislature mandated action on requests within 30 days. The beneficiary is presently notified as well as the provider of denials. The staff indicated that a new form is being developed that will also advise beneficiaries of their fair hearing rights. This process should be completed within 60 days.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

   a. Are physician fees being limited?

Physician fees are reimbursed on the lower of Medicare levels or a maximum fee schedule. The fee schedule is based on the fiscal year 1977 Medicaid payments which were based on 1975 charges. They were adjusted downward by 3 per cent. This level is approximately the same as the 1975 Medicare reimbursement levels.

The maximum fee schedule was implemented effective October 1, 1977. The legislature had mandated a fee schedule for the biannium ending June 30, 1979. As part of a cost-containment program, the agency was directed to reduce fees by 10 per cent. This was accomplished by implementing the 3 per cent reduction and by withholding a 7 per cent increase. The staff indicated that there has not been any real effect on provider participation, which remains good. The level even after the cut is fairly high for physician reimbursement. The fee schedule is compiled on a statewide basis without regional variations.

   b. Are formularies for drugs being restricted?

Maine does not use a formulary, but instead uses therapeutic classes (see Maine-4). Most legend drugs are covered. The only over-the-counter drugs included are insulin and artificial tears. Certain classes of drugs, including amphetamines, are subject to prior authorization. Amphetamines are only authorized for

treatment of hyperkinesis or narcolepsy. Prior authorization of additional drugs has been largely abolished. The staff indicated that in practice, only quadriplegics and dialysis patients can receive additional drugs including over-the-counter items.

Reimbursement is based on MAC and actual acquisition costs. Estimated acquisition costs are not used. The staff indicated that reimbursement based on EAC was cost-ineffective since pharmacies could make a profit on some purchasing. Average actual acquisition costs are entered into the computer. A provider who bills for costs significantly over the average actual acquisition costs will be identified for audit review.

Dispensing fees are set presently at $2.00. The staff indicated that they will be raised to at least $2.70 effective probably November 1, 1978. Maintenance drugs are limited to a minimum 30 day supply or 100 unit dosage. Prescriptions must be dispensed within 30 days. Up to 5 refills are permitted. Prescriptions, including refills, may not be filled beyond 6 months.

Vitamin B-12 injections and cough and cold preparations are covered for certain diagnoses, such as emphysema. The staff acknowledged that the exclusion of over-the-counter drugs has led to some change in prescribing habits towards legend drugs.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

    a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Maine has a program of catastrophic illness coverage reimbursed with state-only funds. This program was established effective July 1, 1974. Eligibility is on an individual basis for a period of 1 year. Individuals must apply for all other health benefits available, and must pay substantial amounts before coverage is established. Patient-pay amounts are 20 per cent of net income before taxes plus 10 per cent of liquid assets when net worth exceeds $20,000 plus a $1,000 deductible.

Benefits are comparable to, but somewhat more restricted than under Medicaid. SNF care, for example, is restricted to 60 days per calendar year. Five days in the hospital is required. ICF care is not covered. In

addition, there are restrictions on psychiatric and psychological care.

During the period July 1, 1977 through June 30, 1978, 1,464 individuals were aided under the program (approximately 600 at any one time). Expenditures totalled $1,418,431 during this period.

General assistance is administered by towns. If a town spends more than a specified amount, then 90 per cent state funding is triggered. This depends on a town reporting its actual expenses. Thus, figures are only available for the major towns seeking state reimbursement for medical care provided. In August, 1978, 188 cases were receiving general assistance medical care. $12,345 was expended for medical care. The staff indicated that the general assistance program is seasonal with expenditures significantly increasing in the winter and decreasing in the summer. Thus, expenditures for the year probably approximate $200,000.

Applicants are also required to apply for medically needy coverage and for catastrophic illness coverage. In practice, the spenddown under the medically needy program may actually be paid by the town. Catastrophic illness deductibles may also be paid for by the towns.

Effective July 1, 1978, a new requirement was established. State legislation mandated that the state process all applications within 45 days. If eligibility is not processed within the time limits, then an individual must be certified for temporary eligibility. If an individual is ultimately found ineligible for Medicaid, Medicaid expenses for applicants with temporary eligibility will be paid for with state-only dollars.

Maine also operates a medical eye care program for Medicaid and non-Medicaid eligibles. Eye examinations and eyeglasses are reimbursed under this program. $264,000 was expended in fiscal year 1977-1978. $30,000 additional was expended during this period for non-Medicaid patients under the refractive error program for children.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

Maine also operates 2 mental hospitals. The City of Portland also operates a city hospital that has now been mostly converted to ICF beds.

MARYLAND

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Medically needy levels were increased effective July 1, 1978, to (1) $2,300, (2) $2,800, (3) $3,300. These levels had been basically unchanged since the inception of the program in 1966.

AFDC benefits are generally increased each year. A 5 per cent increase was implemented effective July 1, 1977. A 5 cent increase was also made on July 1, 1978.

Unearned income disregards under the medically needy program for aged, blind, or disabled applicants is $7.50. In addition, $8.00 of social security benefits, and/or $4.00 of railroad retirement benefits are disregarded. For other persons, $5.00 per month of unearned income is disregarded. Earned income disregards for blind applicants are $85.00 plus 1/2 of the remainder. For the aged and disabled, disregards are $20.00 plus 1/2 of the next $60.00. Other applicants have an earned income disregard to $5.00 per month.

   b. Are states changing resource criteria?

A variety of assets are exempt under the Maryland medically needy program. These include a home, a car if necessary for employment or medical care or for the purchase of essential household supplies. Cash surrender value of life insurance up to a face value of $1,500 for each person is also excluded. An applicant may also retain non-exempt assets of $2,500 for a single person, plus $100 additional for each additional family member

A 3-year transfer of asset prohibition is applied under the Maryland state plan to the medically needy. There is an intent requirement, and the value of the asset is pro-rated for a period not to exceed 3 years in determining eligibility.

   c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Maryland provides Medicaid for all financially eligible individuals under the age of 21. Such individuals are also eligible for a spenddown if their income exceeds medically needy standards.

d. Are unborn children covered? Are there plans to change such coverage?

Maryland provides Medicaid for families with unborn children upon medical verification of pregnancy.

e. What is status of coverage of AFDC-UF families?

Maryland provides Medicaid for families with unemployed fathers based on the federal definition of unemployment.

f. Are states proposing changes in operation of spenddown?

As indicated in Question 2d, the Maryland program is presently revising the administration of its spenddown program. The staff indicated that the State is reviewing its administration of spenddown in relation to federal regulations and guidelines as an overall part of program improvement activities. Technical assistance is being provided by the Regional Office.

g. What are states doing with regard to 209(b) option?

Maryland is a 1634 state and the staff indicated that there is no intention to utilize the 209(b) option.

2. Compare use and operation of spenddown provision among states.

a. Are states changing income lines or operation of spenddown?

As indicated, AFDC, SSI, and medically needy income levels were increased effective July 1, 1978. In addition, because of some compliance issues, administration of the spenddown program is also likely to change.

b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

Maryland is not a 209(b) state.

c. What groups use the spenddown provision? How is public informed about spenddown provision?

No demographic characteristics were available on the portion of the medically needy population utilizing the spenddown program. The staff indicated that no outreach is conducted on spenddown eligibility because the

institutional providers do an adequate job of advising potential eligibles about the program.

d. How is spenddown administered?

A 6-month accounting period is utilized for spenddown eligibles. A 12-month eligibility period is used for institutionalized persons. A Form 216 (included as Maryland-1 is used for indicating the spenddown liability of the individual and the amount which will be paid by the Medicaid program.

Incurred medical expenses from three months prior to the date of application may be considered in a spenddown situation. Assuming that an individual applies in April and has medical expenses in January of $295, February of $100, and $50.00 in March, and has a liability of $300, eligibility would be certified for only a 3-month period beginning with April expenses. This would be accomplished in the following manner. The local office would begin in April and look to see whether the individual has incurred $300 in medical expenses. If $300 in medical expenses has not been incurred, the local office would look at March. Since only $50.00 worth of medical expenses were incurred in March, the local office would then look at February. Since only $100 in medical expenses were incurred in February, bringing the applicant's total up to $150, eligibility would still not be established. The local office would then look at January. Sometime in January, the applicant would have exceeded the $300 liability. Eligibility would therefore be established, and the beneficiary would be certified for 3 months beginning in April's bills. The $95.00 of February's bills incurred over the liability, and the $50.00 in March's bills would not be covered.

The regional office has taken exception to certain procedures in the Maryland spenddown program. As discussed earlier, the Maryland spenddown procedure is being reviewed and will likely undergo some change.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

A few absolute limits are imposed under the Maryland medical program. Optometric services are limited to 1 examination per year, for example, for children unless prior authorized. There are no limits on the number of home health visits that may be provided. Inpatient psychiatric care in general acute hospitals is limited to 28 days. Most other services are theoretically unlimited although subject to prior authorization.

A variety of limitations were implemented effective January 1, 1976 regarding dental services, podiatry services, prescribed drugs, and medical supplies and equipment. (See Maryland-2.) Like most states, the Maryland program went through a fiscal crunch during this period and significantly limited many optional services. Podiatrist services, for example, are now limited to diagnostic and surgical procedures and routine foot care visits for those patients with diabetes and vascular conditions. (Limits are described in Maryland-3.)

b. What changes are anticipated in coverage of optional services?

Some expansion of optional services is likely according to program staff. Adult day-care programs are being considered. An expansion of the over-the-counter drug formulary is also being reviewed. Mental health services are likely to be expanded in order to improve reimbursement for these services. Presently, psychiatrists are reimbursed on the same basis as physicians ($8.00 a visit). Psychologists are reimbursed as clinic services. The state is seeking an 1115 waiver to implement an adult day-care program effective July 1, 1979. (See Maryland-4.)

The Medical Care Advisory Committee is reviewing the provision of medical transportation. The present program appears inadequate and the Committee is looking at the provision of these services by county health departments and by those facilities such as hospitals that have medi-vans.

c. Are copayments being imposed? If so, at what level and on what services?

A $.50 copayment is imposed on prescription drugs. One important feature of the Maryland Medicaid program is that these copayments are carefully treated as medical expenses for institutionalized recipients. For recipients with outside income, therefore, personal needs allowances are increased beyond the $25.50 level utilized by Maryland. This copayment is imposed on EPSDT services as well. The imposition of copayments on EPSDT has been raised as a compliance issue.

d. Is prior authorization being imposed?

Prior authorization is imposed on a variety of services. Dental services, durable medical equipment, podiatry services, vision care services, and wheelchair vans are subject to staff review under prior authorization. These

staff reviews are usually backed up by medical consultants. In many cases, these requests are handled by telephone. The recipient does not receive notice in Maryland but does have a right to a fair hearing and recourse to a board of review if aware of his/her appeal rights. Prior authorization is usually provided on an immediate basis.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

   a. Are physician fees being limited?

No limits exist on the scope of physician services under the Maryland program. The major problem has been low fee levels due to a state fee schedule which establishes a cap that is usually under the usual and customary charges profile. Home and office visits, for example, are limited to $8.00. Actually, this amount represents an increase effective July 1, 1978. It was raised to $7.00 the previous July, and had been $6.00 for several years before. In-hospital services are based on a particular fee for the type of procedure. In-hospital rates have also been increased incrementally over the last 2 years. (See Maryland-5.)

The staff indicated that there has been a problem with physician participation in the program. This was especially crucial with regard to OB/GYN services in some counties. As a result, OB/GYN rates were also increased. (See Maryland-6.)

   b. Are formularies for drugs being restricted?

Maryland covers all legend drugs in its Medicaid program. Reimbursement is based on MAC and EAC with a $2.45 dispensing fee (up from $2.25 effective July 1, 1978). Non-legend drugs other than insulin are not covered. Limits are described in regulation 10.09.03 (included as Maryland-7).

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

   a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Effective January 1, 1979, a prescription drug program is being implemented for individuals with income up to $1,000 over the medically needy levels. State reimbursement will be the same as under the Medicaid program, but a $1.00 copayment will be imposed under the state-only program. This drug program will use a 1-year accounting

period. It was implemented after strong advocacy by senior citizen groups. A 12-month certification period for nursing home residents will be used for institutionalized as well as non-institutionalized individuals, with automated determinations of eligibility. Local offices will explain the program and many institutional providers will share in the cost of the program by having eligibility technicians on site. (See Maryland-8.)

Maryland also has a GPA (General Public Assistance Program). Under this program state medical assistance is provided for non-Medicaid eligibles with state dollars. Individuals may qualify by having incomes under the income standards or by spending down to the income standards.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to the above programs, services are provided for indigents through state facilities for mental illness, mental retardation and chronic diseases, and through the acute care facility operated by the University of Maryland.

MICHIGAN

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

a. Are states changing income criteria?

Michigan provides optional supplements for SSI beneficiaries. Effective July 1, 1978, these levels were increased by the federal cost-of-living increase and by a retroactive increase on the state share. Effective October 1, 1978, an additional increase was made on the state share. (New SSI supplementation rates are set forth in Michigan-1.)

Effective October 1, 1978, AFDC rates were also increased. Medically needy levels are set at 100 per cent of the AFDC or SSI need standard, whichever is higher. They were originally pegged at 110 per cent, but during the fiscal crunch in late 1974 and early 1975 they were reduced to 100 per cent of the AFDC or SSI need standard. (These standards are set forth in Michigan-2 and -3.)

b. Are states changing resource criteria?

SSI resource standards are also used for the medically needy. For families larger than 2, $200 additional is added on for each additional family member. A house and adjoining land are exempted as well as a car.

For AFDC families, non-exempt resources are limited to $1,500 for an individual or $2,000 for 2 or more. A car is limited to a value of $750.

A transfer of property prohibition is applied to AFDC and all medically needy families. It is a 1-year transfer of asset prohibition with an intent requirement. The staff indicated that while it is a rebuttable presumption, it is often overcome. The disqualification may be for more than 1 year because the value of the asset is pro-rated based on the need standard. An informal notice of non-compliance has been filed because this transfer of asset prohibition applies to SSI-linked medically needy individuals. The staff indicated that of the 27 fair hearings held between August, 1977 and July, 1978, 70 per cent have been lost by the state on the divestment issue.

In the situation in which one spouse becomes institutionalized, the state continues to exempt the property.

This is accomplished by treating the institutionalization as an indefinite extension of a temporary absence with the family aided as an AFDC-linked family with deprivation based on incapacity.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Michigan provides Medicaid for all financially eligible individuals under the age of 21. Financial eligibility is based on the medically needy standards.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children were added to the Michigan AFDC program effective October 1, 1978. Unborn children were covered for a short period in 1974. A $14 additional need is recognized for the unborn child. Coverage begins on medical verification of pregnancy. For the medically needy, the $14 need figure is not included in determining eligibility.

e. What is status of coverage of AFDC-UF families?

Michigan provides AFDC and Medicaid for families with unemployed fathers based on the federal definition of unemployment.

f. Are states proposing changes in operation of spenddown?

Michigan had been using paid expenses to satisfy spenddown liabilities. Effective March 1, 1978, the state began using incurred expenses.

The only major change being considered in the operation of the Michigan spenddown program is a possible change in the accounting period to one month.

g. What are states doing with regard to 209(b) option?

Michigan is now a 1634 state. It was a 1634 state by practice for some time although it did not have a contract with the Social Security Administration. It now has a contract in effect. It has no intention of becoming a 209(b) state.

2. Compare use and operation of spenddown provision among states.

   a. Are states changing income lines or operation of spenddown?

As indicated, Michigan has increased its income criteria for spenddown eligibility.

   b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc?

Michigan is not a 209(b) state.

   c. What groups use the spenddown provision? How is public informed about spenddown provision?

No state outreach is conducted with regard to the medically needy program. Fliers and speakers are provided to community groups. The staff indicated that most individuals find out about the program through institutional providers.

No demographic characteristics exist on the portion of the medically needy population using the spenddown program.

   d. How is spenddown administered?

Spenddown eligibility is determined using a 6-month accounting period except for long-term care. A 1-month accounting period is used for long-term care. Institutional cases are described by the state as "patient pay amount cases." Liability determinations utilize different income disregards depending on the linking factor. AFDC-linked medically needy individuals, including "Ribicoff children," have eligibility determinations based on AFDC income disregards. SSI disregards are used for other medically needy individuals.

Applicants receive a Form DSS 114 to compile expenses. (A copy is included as Michigan-4.) If an individual incurs medical expenses in excess of his liability, the state pays the difference and assigns the expenses to be satisfied by the beneficiary to the institutional provider. There is no on-line budgeting capability, but there is some talk of designing this into the MMIS eligibility subsystem.

Two comments were expressed by the staff with regard to the spenddown program. First, the staff criticized the Utah approach where the liability is treated as a premium to be paid to the state. In that case, the staff noted, the client can lose if medical bills do not equal or exceed the spenddown. The staff also noted that a simplification of eligibility would be better. An ideal system would be to have non-linking federal financial participation with only income and resource criteria. The staff described this as "no boxes."

3. Identify and analyze current and potential benefit restrictions under Medicaid.

    a. What limits are being considered on amount of service?

A 2 visit per month limit on physician visits was included in the state plan for a short period but it was never really implemented. It was deleted in the fall of 1976.

Home health services must be provided by a Medicare-certified agency. They must be ordered by a physician, but there are no limits on the number of visits.

No limits are applied to inpatient services. A post-payment, post-service review is presently applied to all claims beyond the 75th percentile of PAS-LOS standards. This review monitors compliance with program requirements (coverage and limits) for all hospitals, as well as medical necessity for non-PSRO hospitals.

Outpatient psychiatric services are limited to 5 visits per year by an M.D. or D.O. or 10 visits per year by a psychiatrist. Beyond those limits, services must be obtained from a mental health clinic or in an inpatient setting.

Chiropractic services were limited to 6 visits per month or 24 visits per year. This has now been raised to 10 visits for the first month and 6 visits for each succeeding month up to 24 visits per year. Exceptions may be made when documented as necessary. This change in policy was effective November 1, 1978.

    b. What changes are anticipated in coverage of optional services?

The staff indicated that coverage of durable medical equipment is likely to increase. Coverage of these services requires prior authorization.

Abortions had been covered with 100 per cent state funding, with coverage not limited to therapeutic abortions. Effective October 1, 1978, the legislature limited abortion funding to $1.00 for elective abortions. This was vetoed by the governor. A supplemental appropriation was passed which effectively continued funding for abortions through December 31, 1978. The legislature is currently considering a bill which would prohibit state funding of abortions through the Medicaid program.

The staff indicated that there had been some problems with coverage of non-emergency transportation. Generally these services must be obtained from a local office now.

One possible change in coverage of optional services is a proposal being prepared by the Health Care Institute in Detroit. This would establish a fee per visit with a limit based on the aggregate number of visits by the Medicaid population. The Health Care Institute would be at risk for the total cost. Staff indicated that a benefit of this type of approach over an HMO might be reduced marketing problems since an individual need only register when services are sought. In addition, there is a protection against skimming since the physicians who are employed by HCI cannot also be enrolled individually in the Medicaid program.

Costs would be set on the basis of fee-for-service averages in the Wayne County area. Some services not presently reimbursed under the Medicaid program would be provided, but would not be reflected in the rate. These would include health education and nutritional counseling. Money is being sought from the Health Care Financing Administration by HCI. Drugs would be included with clinical pharmacists and social workers available for counseling. HCI's hope in the project is that case management will discourage episodic care.

The staff indicated that MSA hopes to eliminate the limit on long-term care physical therapy effective December 1, 1978. Presently there is a 90-day limit. They would also plan to include occupational and speech therapy effective December 1, 1978, which were eliminated in in the cutbacks of 1975. Special infant formulas will also be included as a pharmacy item and there is some consideration being given to including additional over-the-counter drugs in the prescription drug program.

c. Are copayments being imposed? If so, at what level and on what services?

A $2.00 per reimbursable visit copayment is imposed on adult vision services. A $3.00 per reimbursable visit copayment is imposed on adult dental services. A pharmacy copayment of $.50 per prescription drug (either new or refill) was imposed in 1976 as a cost control. In April, 1977, the state attempted to eliminate this copayment for institutionalized recipients. This was rejected by HEW. In July, 1977, the state eliminated the drug copayment completely.

d. Is prior authorization being imposed?

Prior authorization is required for most surgeries which have cosmetic implications, selected dental services, durable medical equipment, physical and occupational therapy, inpatient psychiatric, vision services and most ophthalmic materials, some selected drugs and medical supplies, and out-of-state medical care.

Responsibility for prior authorization is shared on a limited basis with the Department of Public Health's Bureau of Personal Health Services and the Department of Mental Health. The Medical Services Administration has responsibility for reviewing requests for physical therapy, medical supplies for individuals over the age of 21, and dental services. This is done through central office staff, and some district staff in the case of dental services with some use of contract consultants. Provider authorization interaction by the program is with the provider, who receives notice of approval or denial. The beneficiary does not directly receive a notice of denial. Prior authorization for such drugs is limited to those classified as anorexants which are not covered exept for treatment of narcolepsy and hyperkinesis.

The staff indicated that the general policy is to use a professional staff person to evaluate a request for professional services. Dental reviews are made by the Dental Division. They are usually done in area offices in which the provider is located, with relocations of responsibility considered based on shifts in demand for authorization requests. Where prior authorization is required, the dental provider must submit a request encompassing all the services necessary to complete the stated treatment plan within a reasonable period. The turnaround time for review of dental requests varies from approximately 6 hours to 5 working days.

Review of vision services requests usually has a two to three day turnaround. The Department of Mental Health is responsibile for responding to prior authorization requests for mental health services.

Occupational and speech therapy are not presently reimbursed as covered services. The staff indicated that the costs of these services are allowed as an offset to the patient pay amount in the long-term care setting if prior authorized. (See Michigan-6 and -7.) However, preparations have been made to allow these as covered services beginning December 1, 1978. The staff also indicated that 60 per cent of requests for approval of durable medical equipment are approved. (Prior authorization forms are included as Michigan-5 through -11.)

In addition to the procedures listed on the descriptive sheet (Michigan-12), intestinal bypass procedures are also subject to prior authorization.

Prior authorization is also conducted for out-of-state medical care. However, residents living in borderland areas of a state contiguous to Michigan, described as the usual and customary medical service area for routine care, are exempt from obtaining prior authorization for routine medical care in that area. There is also some prior authorization of nutritional supplements for special cases of malabsorbtion which do not fall under routine coverages for children with specified conditions.

Level-of-care determinations related to the long-term care setting are still presently conducted by the Department of Public Health. That Department also is responsible for prior authorization requests for all hearing services, including hearing aids for all recipients, as well as durable medical equipment, orthodontics, prostheses, shoes and medical supplies for recipients under 21.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

   a. Are physician fees being limited?

Physician services are reimbursed on a modification of the Medicare system. The staff indicated that the state uses regional ceilings by class of physician and specialty and subject to the Medicare index value. Individual practitioner charges, however, are not used. The state uses the 1971 UPC, while Medicare uses the 1969 UPC with some modification from California, New York and Michigan RVS. If there is a perfect match in the procedures, the state uses a conversion code. This applies to about half of the procedures. Fee profiles are updated annually when Medicare screens are updated.

In 1975 the legislature cut fee screens by 11 per cent. This was restored in 1976 and then recut by 4 per cent.

This was restored in 1977 with an increase for all services which could be done in ambulatory settings. In 1978, profiles were re-updated for both ambulatory and inpatient procedures.

The staff indicated that physician participation is now very high after some drop in 1975 after the reduction in fees.

Staff indicated their displeasure with the Medicare method and indicated their support for the present Michigan system. They indicated that looking at a physician's usual fees is often wasteful. They also indicated some support for an encounter system for small physicians to encourage participation.

b. Are formularies for drugs being restricted?

Michigan does not use a formulary. Drugs are reimbursed on the basis of acquisition costs (MAC and EAC) plus a professional fee. The dispensing fee was updated effective October 1, 1978, to $2.50 from $2.40. This was retroactive to the date of a supplemental bill. In addition, the fee was increased prospectively to $2.75 effective October 1, 1978.

Coverage of most over-the-counter drugs was eliminated by the legislature in the 1975 fiscal crunch. Insulin, family planning drugs and supplies, and drugs for treatment of chronic renel disease are still reimbursed. The staff indicated that the state is considering reinstating coverage of selected OTCs.

The staff indicated that the state is considering a capitation payment for drugs in long-term care settings.

c. Miscellaneous.

Presently, hospital costs are based on a hospital cost index. A base year is established for total costs excluding certain fixed costs. An index number is applied to all other costs based on the composite of the components included among those costs. These might include, for example, labor and supplies. Thus, reimbursement is based on the following formula: base year including costs times index plus current year fixed costs. These are allowed up to the Medicare limits with some possibility for exceptions. This has been applied as the formula since October 1, 1976.

Hospitals which seek an exception must justify the reasonableness of their costs. In doing so the state applies essentially a "prudent buyer" approach to ensure that the services could not have been provided for a

lesser cost. Cost settling is then based on the lesser of costs or the index figure. The legislature through P.A. 401 Section 51 has mandated that prospective reimbursement be implemented for hospitals effective January 1, 1979. MDSS staff are now negotiating with the Michigan Hospital Association the design of such a system. MDSS staff feel that if present design criteria is adhered to, the new system could be an effective cost-containment measure.

In long-term care, reimbursement is based on prospective reimbursement with a disincentive for not providing quality services.

Home health services are reimbursed on a retrospective cost-settling basis.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

    a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Michigan has a variety of programs for non-Medicaid eligibles. Approximately 2 years ago the state assumed the responsibility for the general assistance-medical care program. This is still in a transition stage. There are some policy directives from the state for administration, but these are very skimpy. Eligibility requirements in broad areas of coverage are explained.

Counties may provide care on an outpatient basis including pharmacy and physician services. Prosthetic devices such as hearing aids, glasses, and dentures are limited to individuals who need such services for employment.

Eligibility requirements are somewhat restrictive. Any cash resources in excess of $50 are considered available. Most non-cash resources are exempt including a home, a car, household goods, personal effects, $1,000 cash surrender value life insurance, and one burial plot.

The need for care must be prior authorized by a physician. The county rates for reimbursement that used to be in effect are still used. As a result, there is presently tremendous variation in the program. In addition, there is very little data on costs.

Costs of care are computed on a reduced sliding scale for county contributions. By 1980, the program will be 100 per cent state funded. Presently, the counties compute eligibility based on county assistance standards. If

an individual has income under the need standard, then the county provides cash or vendor payment assistance and medical assistance. This is part of the proposed state program to be implemented January 8, 1979. A 6-month spenddown will be utilized, as in MA now. Generally, eligibility is on a monthly basis, although some counties give extended authorizations. Present costs under the program are estimated at approximately $8 million per year. (See Michigan-13.)

Michigan also has an "afflicted adult hospitalization" program. The social services board in each county has responsibility for this program which is 100 per cent county funded and administered. The counties determine eligibility and standards of assistance and negotiate with hospitals to establish rates. The only state reimbursement is to those counties that provide services for non-residents.

Effective January 8, 1979, eligibility for medical assistance under the GA program will be at the state general assistance level. Eligibles will still not receive Medicaid cards, and will be subject to prior authorization for all services. Implementation of the program has been delayed by financing. Claims will be processed, however, on the same basis as Medicaid claims and paid at the same levels. Local social service boards can supplement coverage, but there is no indication that they are. A reimbursement agreement is required for all hospitalization.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to the above services, many counties have their own facilities for long-term care.

MINNESOTA

1. Analyze potential changes and trends in eigibility criteria for Medicaid.

a. Are states changing income criteria?

The state increased its income criteria for the SSI and AFDC programs on July 1, 1978. This was accomplished by legislation at the beginning of the fiscal biannium.

Another major change in income criteria in the state relates to the use of income disregards. AFDC-linked medically needy recipients are not presently receiving the AFDC income disregards; SSI-linked medically needy recipients are not presently receiving the SSI income disregards. Such recipients only may deduct work-related expenses from gross income. Residents in long-term care who work in sheltered workshops receive a $50 income disregard. The state is moving to a system of applying the regular income disregards for medically needy recipients.

Effective July 1, 1978, the personal needs allowance for institutionalized individuals was increased to $30.00. (A copy of present need standards is included as Minnesota-1.)

b. Are states changing resource criteria?

Effective July 1, 1978, the state increased the exempt equity value of real property. This value was originally $15,000, it was raised first to $25,000, and effective July 1, is now $28,500. In addition, the legislature enacted an escalator clause based on the cost of living to take effect each July 1. Applicants may own a car worth less than $1,650 market value. Prepaid burial contracts must be less than $750 to be exempt and can accrue interest equal to $200. Cash and negotiable assets may not exceed $750 for an individual or $1,000 for a couple. For each additional person, $150 is added.

The state has a transfer of property prohibition. It is a 3-year period with a rebuttable presumption. If the property was transferred within 3 years prior to applying for assistance or while on assistance, the state reviews whether reasonable consideration was received. If reasonable consideration was not received, the burden is

shifted to the applicant to show that it was not for the purpose of obtaining eligibility. If this burden is not met, the applicant or recipient is disqualified for 3 years from the transfer.

In the situation where a spouse is institutionalized, the family is still treated as an intact family since it is an involuntary separation. This is done for an indefinite period. The excess value of the house is therefore waived as a resource.

The resource standards for AFDC families are somewhat lower for net equity of a home. The only item of increased value would be for burial contracts since each member of the family may have a burial contract.

An individual with a home in excess of the resource standard may still be certified for eligibility if the county board determines that it would be undue hardship to deny coverage. County boards consist of county commissioners and 2 lay members. Such an individual becomes a Medicaid eligible. The Regional Office has raised some questions concerning the validity of this policy.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Minnesota covers all financially eligible children under age 21.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are covered only for the last trimester of pregnancy. A pregnant woman under age 21 could be covered as a Ribicoff child prior to the last trimester, however.

e. What is status of coverage of AFDC-UF families?

Minnesota provides AFDC and full Medicaid coverage for families with unemployed fathers.

f. Are states proposing changes in operation of spenddown?

Except for the change in income standards and income disregards, no changes are projected in the operation of the spenddown program.

g. What are states doing with regard to 209(b) option?

Minnesota has been a 209(b) state since January 1, 1974. The only examination for eligibility of SSI recipients is a review of resources and relative responsibility for SSI recipients under 18 years of age.

2. Compare use and operation of spenddown provision among states.

a. Are states changing income lines or operation of spenddown?

Except as previously described, Minnesota is not changing its income lines or operation of the spenddown.

b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

Both spenddown programs use a 6-month accounting period for ambulatory patients and a 1-month accounting period for institutionalized and some chronic outpatient ailments such as dialysis. Non-cash financial eligibles are certified for a 12-month period.

c. What groups use the spenddown provision? How is public informed about spenddown provision?

Minnesota has not developed the demographic characteristics of the group using the spenddown provision. The public is generally informed about the spenddown provision through institutional providers. A recipient who applies for benefits and is financially ineligible will be informed of the medically needy program.

d. How is spenddown administered?

An individual who applies for the medically needy program will receive a form DPW-1844 (included as Minnesota-2) to list incurred medical expenses. Once an individual brings in incurred expenses equal to or exceeding the liability, eligibility goes back to the date that the individual first exceeded the liability. In cases where the individual exceeds the liability, payment will begin with that portion of the bill exceeding the liability based on a chronological tracking of medical bills.

Minnesota uses incurred medical expenses. In monthly cases, however, the county monitors the actual payment of bills to insure that the liability is actually being met. Usually, this means that the county contacts the nursing home to insure that the non-institutionalized spouse meets his/her share of the deemed obligation.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

   a. What limits are being considred on amount of service?

Coverage of abortions was in flux for some time. Beginning September 23, 1977, there had been no abortion coverage in Minnesota. The state is now including this as a service. The previous standard had been struck down by the State Supreme Court because it had not been promulgated under the State Administrative Procedure Act. Present coverage utilizes the federal Medicaid criteria except that coverage is not provided where two doctors certify that the patient will suffer long-lasting effects.

Coverage of services is described in DPW 47 (included as Minnesota-3.)

   b. What changes are anticipated in coverage of optional services?

The state had covered individuals in institutions for mental diseases. They were paying if the institution was certified as an intermediate care facility. The federal government had required elimination of this coverage. As a result, the state is not paying either for services rendered inside the institution or for outpatient services for institution residents. No other changes are anticipated in coverage of optional services. The state has a broad program. The scope of services is established by the legislature. Thus, the legislature would have to exclude certain services from coverage if these services are to be eliminated. The staff indicated that this is unlikely due to political realities.

   c. Are copayments being imposed? If so, at what level and on what services?

Copayments are not presently being imposed under the program and the staff does not want to see copayments as a program requirement. The staff indicated that they had fought to have copayments made optional in the federal legislation rather than mandatory.

d. Is prior authorization being imposed?

Prior authorization is extensively used in the Minnesota program and the staff indicated strong belief in prior authorization as a control on appropriateness and thereby cost-containment. The staff indicated a desire to have more individuals perform prior authorization functions.

Prior authorization is required for more than 10 hourly sessions by a psychiatrist per recipient per calendar year. Prior authorization is also necessary for most elective surgery, for durable medical equipment over $200, for many adult and EPSDT dental services, and for some vision care services. Prior authorization requests are submitted on a form (included as Minnesota-4) which varies with the type of service requested. All prior authorization is done centrally within the department. The usual turnaround time is 3 to 5 days. In emergency situations, no prior authorization is required.

There is form notice to the provider. The recipient is also notified if a claim is denied. (A copy of a denial form is included as Minnesota-5.) Advisory committees are used on some prior authorization requests. Crippled Children Services uses the Medicaid panel for child dental services such as orthodontia. The staff indicated that the prior authorization procedures are fairly well accepted by the professions.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physician fees are based on physician profiles. Usual and customary charges are updated annually. Chiropractic services are limited by a maximum fee schedule.

b. Are formularies for drugs being restricted?

Minnesota does not limit drug reimbursement to a formulary. If a doctor prescribes a particular medication on a prescription, the program will reimburse based on the cost of the item plus a 40 per cent mark up. Obviously, in some cases this exceeds MAC or EAC. As a result, the HEW Regional Office has taken exception to this practice. The state is attempting to reach some consensus on a different approach.

Minimum or maximum dosages are not mandated. Instead, physicians are advised that the state would prefer that

not more than a 100 day supply is prescribed. Generic drug substitution is not functioning effectively within the state, the staff indicated. The staff did indicate that the S/UR sub-system for identifying abusers is felt effective. The state is very cautious before initiating action and attempts to counsel abusers. Lock-in is not limited to drug abusers. As indicated, coverage exists for legend and non-legend drugs if a doctor has prescribed. (Quantity quidelines and covered drugs are listed in Minnesota-6.)

Dietary supplements are covered only where prior authorization is obtained. The pharmacy seeks prior authorization, but must have medical verification of the need for the dietary supplement. Such cases are handled in the central office.

c. Miscellaneous.

Home health services are covered if provided by a Medicare-certified home health agency. This agency must be a public non-profit agency since there is no state licensure for private agencies. There are no other limits on scope of services.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Two main programs exist for providing services for non-Medicaid eligibles with 100 per cent state funding. The first of these programs is the catastrophic health expense protection program (CHEPP) effective July 1, 1977.

CHEPP-1 covers everything but long-term care. Coverage is similar to Medicaid except that there is no resource standard. However, to become eligible, the resident must spend 40 per cent of household income up to $15,000, plus 50 per cent of household income between $15,000 and $25,000, plus 60 per cent of household income in excess of $25,000; or $2,500; whichever is greater; or qualified nursing home expenses exceeding 20 per cent of household income. CHEPP pays 90 per cent of the remaining charges and the individual pays 10 per cent.

CHEPP-2 covers long-term care and is for individuals under age 65 who have been in long-term care for at least 36 consecutive months. Because of these limitations, the staff indicated that there is some desire to expand the CHEPP-2 program.

Between July 1, 1977 and June 27, 1978, $312,142 was expended under CHEPP-1; during the same period $55,000 was expended under CHEPP-2.

The other main program is the GA medical care program. This program covers individuals age 21 to 65. Eligibility standards and covered services are the same as Medicaid. GA cash recipients and other individuals are covered. The program was established effective January 1, 1976. Although budgeted for $10 million over the past 2 years, the state is actually spending 2 1/2 times that amount. Expenditures for the period 1980 through 1982 are projected at $40 million dollars.

MISSISSIPPI

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Income standards for the aged, blind, and disabled, under the 209(b) option were increased for eligible individuals to $175 effective July 1, 1978. Previously, it was $150. Eligibility standards for couples, however, were reduced from $300 to $284.10. This decrease resulted because Mississippi was treating an eligible couple as 2 eligible individuals. The income standard for 1 was thereby doubled. The HEW Regional Office rejected this approach since it resulted in criteria more liberal than SSI criteria. Income disregards which had been $7.50 for an aged or disabled individual and $15.00 for an aged or disabled couple were increased, to compensate, to $10.00 for an aged or disabled individual and $20.00 for an aged or disabled couple. Blind individuals also receive an earned income disregard.

AFDC benefit levels were also increased through a 2-tiered process. AFDC grants are determined by subtracting non-exempt income from a need standard and by multiplying this difference by a ratable reduction. That amount is the grant so long as it does not exceed specified maximums per child in the family. The basic need standard was recently updated (January 1, 1977) by consolidating individualized needs into a flat consolidated need standard. (See Mississippi-1.) The ratable reduction prior to October 1, 1978, was 40 per cent. Effective October 1, it will be increased to 50 per cent. Thus, prior to October 1, a family with no outside income received 40 per cent of the need standard, not to exceed the maximum per child.

Maximums per child, effective July 1, 1978, were increased to $60.00 for the first child, $36.00 for the second child, and $24.00 for each additional child. The maximums represent a doubling of the old maximums. Thus, the maximum grant for an adult and 3 children is $120.00 ($60.00 plus $36.00 plus $24.00). The actual grant, however, would also be $120.00 since 50 per cent of a need standard of $252.00 exceeds the maximum of $120.00.

Thus, while benefit levels remain extremely low, there has been a significant increase implemented in the in the program. (See Mississippi-2.)

b. Are states changing resource criteria?

Medicaid resource standards for the aged, blind, and disabled are the same as for the AFDC program. Mississippi exempts a home so long as the assessed value minus encumbrances does not exceed $3,500. If the value exceeds $3,500, the family is rendered completely ineligible. The staff indicated that this is becoming a problem with increasing property values.

A car of at least 7 years old is also exempt. If it is less than 7 years old, then the NADA value minus $800 less encumbrances is counted in the property reserve. Property reserves for an individual cannot exceed $750. County assessed value less encumbrances is the basis for valuing property reserves. For a couple and family this cannot exceed $1,500.

Mississippi also has a transfer prohibition. (See Mississippi-3.) There is an intent requirement for all transfers where the individual has not received reasonable return within 2 years of applying for aid. A 1-year penalty is imposed for improper transfers. If an individual becomes a "community problem" because of inadequate income and resources, then the 1-year penalty can be waived, however.

The present income figure for hardship eligibility is $70.00 per month, but the staff has indicated that this requirement is being removed. The staff indicated that this income limitation had prevented any waivers from being granted since the recipients generally had some income which rendered them ineligible for the waiver. Most often this occurred with regard to nursing homes.

Where a spouse becomes institutionalized, Mississippi continues to exempt the home if occupied by a spouse and/or dependent child or so long as a homeowner's exemption continues to be granted. In addition, under the 209(b) option, the state considers relative responsibility for an indefinite period.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Mississippi provides Medicaid for those financially eligible children under the age of 21 for whom the state or county welfare agency has custody and financial

responsibility and who are in foster homes or private child-caring institutions.

Disabled children under the age of 18 years were added to the Mississippi Medicaid program effective July 1, 1978. This addition was necessary because children under the age of 18 were not covered under the state's old AABD program.

d. Are unborn children covered? Are there plans to change such coverage?

Beginning July 1, 1978, Medicaid eligibility was provided for unborn children beginning with the fifth month. No cash assistance is provided; eligibility is based on the AFDC need standard with the unborn treated as an additional child.

e. What is status of coverage of AFDC-UF families?

There is no coverage for families with unemployed fathers under either the state AFDC or Medicaid program.

f. Are states proposing changes in operation of spenddown?

The one change that is being made in the spenddown program is a change in the treatment of retroactive expenses. Retroactive eligibility is now being included as an addition to the initial accounting period. Since Mississippi uses a 6-month accounting period, eligibility could be based on 7, 8, or 9 months' worth of expenses. This is being changed so that eligibility for retroactive coverage will be based on a 1, 2, or 3 month accounting period. This change is being initiated because the HEW regional office has taken exception to the present policy. The present policy had been initiated because the HEW regional office had told the state that this was the way eligibility had to be determined. Previously, Mississippi had used a flexible 6-month accounting period which could use the retroactive months if it was favorable to the client.

g. What are states doing with regard to 209(b) option?

In late 1973, the state selected the 209(b) option because of major concern over where program costs would lead. As the SSI rolls and eligibility standards have settled down, this factor is not as significant. There is a concern that money is being spent on administrative

costs that could be spent on services.

The Medicaid Commission is presently conducting a study and considering the options and benefits of continuing as a 209(b) state or becoming a 1634 state. No decision has been reached.

2. Compare use and operation of spenddown provision among states.

   a. Are states changing income lines or operation of spenddown?

As indicated, Mississippi has increased its income lines for operation of the spenddown program. In addition, some changes in operation will be implemented regarding coverage of retroactive expenses.

   b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

Mississippi does not have a medically needy program, and uses a 6-month accounting period for budget determinations. A 1-month accounting period is used for institutional care.

   c. What groups use the spenddown provision? How is public informed.

As in most states, the public is referred to the Department of Public Welfare by the institutional providers in order to apply for spenddown eligibility. Individuals discontinued from cash eligibility are notified of the spenddown program. (See Mississippi-4.)

   d. How is spenddown administered?

When an applicant comes in to apply for coverage, s/he is given form DPW-332 (Mississippi-5). This form is used for compiling medical expenses necessary to satisfy the liability.

Once the liability is met, the client becomes eligible at the beginning of the day in which the liability is met. The state does not split bills. Thus, an individual who applies in January for a 6-month accounting period ending

June 30, might have a liability of $300.00. If the applicant incurs $100.00 in medical expenses on January 2, $100.00 in medical expenses on January 3, and $150.00 in medical expenses on January 4, eligibility would begin at the beginning of the day of January 4. Thus, the state could reimburse the provider for medical expenses used to satisfy the liability.

This approach is not used, however, with regard to nursing homes. In the nursing home setting, fixed expenses as well as the actual income is used to compute a 1-month accounting period.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

   a. What limits are being considered on amount of service?

Limits exist on a variety of services in the Mississippi program. Inpatient services are limited to 40 days per year. Outpatient services are limited to 30 visits per year. The staff indicated that a provider would not necessarily know when this limit had been exceeded. Physician services are limited to 1 inpatient visit per day and 36 long-term care visits per fiscal year.

Home health services are limited to 50 visits per fiscal year. Eyeglasses are limited to 1 pair for eye surgery with no additional coverage except in EPSDT. Optometric services are limited to exams only following eye surgery. Dental services for individuals over 21 are limited to emergency extractions and other dental care necessary for treatment of an acute medical or surgical condition. This limit does not apply to children requiring restorative dental treatment who have been screened under EPSDT.

Dentures are being added to the program effective October 1, 1978. Mississippi also imposes a limit of $450.00 for any surgical procedure done in one surgical sitting by a physician based on a Blue Cross fee schedule (F-450).

   b. What changes are anticipated in coverage of optional services?

As indicated, dentures are being added to the program effective October 1, 1978. They will be limited to 1 set every 6 years. The need must be certified by a physician as medically necessary. No partials will be covered.

Dentures must either be a full upper or full lower, or both. The service will be subject to prior authorization. (See Mississippi-6.)

No other changes are expected in coverage of optional services under the Mississippi state plan.

c. Are copayments being imposed? If so, at what level and on what services?

A copayment of $.50 was imposed on prescription drugs from July 1, 1976 through January 1, 1978. It was eliminated by the Medicaid Commission. As a result, there has been some increase in the number of prescription drugs despite a slight decrease in the Medicaid population. The staff indicated that while it was viewed as a logical control for utilization, it often imposed a real hardship for some needy individuals. The staff indicated also that while there was some concern that expenditures for drugs were too high, nursing home costs remain the main concern.

d. Is prior authorization being imposed?

Prior authorization is imposed on long-term care placements, on extraction of more than 6 teeth at 1 sitting, on dental care that is adjunct to treatment of an acute medical or surgical condition, on medical transportation of more than 100 miles, and, effective October 1, 1978, on dentures. (A dental authorization form is included as Mississippi-7.)

A provider initiates a request to the Medicaid Commission for staff review. The staff indicated that few are denied except for long-term care placements. Turnaround is usually on the day received. Ambulance requests are prior authorized by telephone. The beneficiary is not notified directly, but in nursing home settings the sponsor (usually a relative) of the patient is notified.

One interesting sidelight of the nursing home level-of-care determination is a recent study conducted by the State. The State has contacted homes throughout the Medicaid program to find out the number of long-term care residents who have had no contact with family or sponsor in the last 12 months. Approximately 650 out of the 9,000 nursing home residents were described as "abandoned." The state is looking for possible approaches to this problem including assigning contact people for each patient. The staff indicated that while this will not save money, it will be humane.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

   a. Are physician fees being limited?

Mississippi uses the 1964 California RVS for procedure codes. Surgical procedures are limited to the Blue Cross F-450 schedule. A fee schedule was also prepared for non-surgical procedures based on the level of reimbursement for surgical services.

Effective July 1, fees for physicians were increased by 50 per cent. An office visit went from $6.00 to $9.00. The Blue Cross fee schedule limit went from $300.00 to $450.00.

   b. Are formularies for drugs being restricted?

Mississippi utilizes a drug formulary. MAC and EAC pricing are used with a dispensing fee of $2.25. This dispensing fee has been in effect since approximately April of 1977. Maximums are assigned to drugs in addition to those under the federal MAC. The staff indicated that generic drug substitution will likely be enacted in the near future, but because of the maximums assigned to drugs under the Mississippi Medicaid program it already exists in practice for Medicaid beneficiaries. (A copy of the Pharmacy Manual is included as Mississippi-8.)

   c. Miscellaneous.

The staff indicated that there are no organized efforts to limit hospital expenses. The major limitation on nursing home costs is a $2.00 limit per patient per day that has been imposed on profits for the nursing home. This was imposed as a control on reasonable costs and was based on a study of nursing home costs. If a home's costs are less than the 80th percentile of nursing home costs, the home receives the difference up to the $2.00 per patient per day profit figure.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

   a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding.

Mississippi provides no coverage for the general assistance population or for any state-only categories. Some counties have an indigent fund.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

Mississippi operates a number of charity hospitals which are funded by the state. There are appoximately 5 hospitals including the University Hospital in Jackson. During the period July 1, 1977 through June 30, 1978, University Hospital expended approximately $4 million in uncompensated care. The state funds to the remaining 4 charity hospitals in Mississippi during the 1978 fiscal year amounted to $5,620,892. In addition, the State distributed funds to the Mississippi Hospital Commission for payment for inpatient care for indigents in private hospitals of $693,633. Thus, state expenditures for care of indigents in fiscal year 1978 exceeded $10 million.

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Nebraska has continued to increase income criteria for Medicaid eligibility. Nebraska converted from an individualized need standard to a flat grant system in August, 1977. Initially, benefits were set at $138 for basic needs plus $130 maximum for shelter plus special needs. These were raised effective August, 1978 to $148 plus $130 maximum for shelter plus special needs. A special 1-year grandfather provision was also enacted to minimize hardship for marginal eligibles. Protected income levels will be increased effective January, 1979 from $3,000 for an individual to $3,100.

Under the 209(b) option, only a $7.50 income disregard is applied to unearned income. Earned income is subject only to a $20 plus 1/2 of the remainder (up to a total of $50) disregard for aged and disabled recipients. For blind recipients, the first $85 plus 1/2 of the remainder of earned income is disregarded.

   b. Are states changing resource criteria?

Resource levels have remained relatively constant since September 1, 1977, and are expected to remain unchanged. Cash resource limits are identical to SSI ($1,500 for an individual, $2,250 for a couple). Additional individuals in the family budget unit receive a $25 increment.

Nebraska exempts a home unless the county board determines that it is unusually luxurious. (The standard to be applied in determining eligibility is included as Nebraska-1.) Burial policies are included as a resource if actually available to meet current needs.

Nebraska applies a transfer of asset prohibition. Transfer of a home is permissible if the individual continues to actually occupy the home for at least 1 year. (See Nebraska-1.) An applicant/recipient who deprives him/herself of resources to qualify or maintain eligibility for medical assistance thereby becomes ineligible. Ineligibility continues for such time as the value of the resource disposed of might reasonably be expected to meet the medical and maintenance needs of the individual.

Equity in a car is limited to $1,200.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Nebraska provides Medicaid for the following subclasses of financially eligible individuals under the age of 21: (1) wards of the State of Nebraska or of the County Division of Public Welfare who are under age 21 and living in foster homes, cooperating public institutions, or private facilities; (2) essential children, as defined by SSI, of non-cash Medicaid recipients; and (3) children who receive SSI and meet the definition of a dependent child.

d. Are unborn children covered? Are there plans to change such coverage?

Families with unborn children are provided AFDC and Medicaid upon medical verification of pregnancy. The parents of a pregnant minor are responsible for the unborn child.

e. What is status of coverage of AFDC-UF families?

Families with unemployed fathers are included in both the state AFDC and Medicaid plans based on the federal definition of unemployment.

f. Are states proposing changes in operation of spenddown?

General revisions are being considered in the operation of the Nebraska spenddown program.

g. What are states doing with regard to 209(b) option?

Nebraska is a 209(b) state and has no intention of changing.

2. Compare use and operation of spenddown provision among states.

a. Are states changing income lines or operation of spenddown?

As indicated, Nebraska has increased income lines for the spenddown program.

b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

The spenddown provision under the 209(b) option is operated the same as the medically needy program.

c. What groups use the spenddown provision? How is public informed about spenddown provision?

The staff indicated that no demographic characteristics were available for those individuals using the spenddown provision. The most telling figure, however, is that of the 10,859 Medicaid recipients who are not receiving a cash assistance payment, 8,626 are aged, blind, or disabled. Of these 6,699 are aged. Aged, blind, and disabled persons who are not receiving cash assistance utilize $31,953,691 of the $34,169,866 in annual expenditures.

Generally, the public is informed of the spenddown program through 1 of 2 ways. Most individuals learn about it through institutional providers. Others learn about the program when they applied for cash assistance and are rejected because of excess income. (A copy of the notification form is included as Nebraska-2.)

d. How is spenddown administered?

Applicants bring provider bills to the county. They are recorded on excess income obligation claim forms (included as Nebraska-3). These bills are entered into the computerized eligibility sub-system. When an individual's liability is satisfied, a card is generated from the state at the beginning of the next month. The eligibility card is retroactive to the date that the spenddown liability is satisfied.

A 1-month accounting period is used for institutionalized individuals; a 6-month accounting period is used for non-institutionalized persons.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

Few limits are imposed under the Nebraska plan that cannot be extended by prior authorization.

Hospitalization is limited to the 75th percentile of the Central Region length of stay in PSA hospitals. Medical procedures considered "cosmetic" are not covered. Inpatient physician visits are limited to 1 per day. Limits are specifically described in the Provider Manuals (included as Nebraska-4 through -14).

b. What changes are anticipated in coverage of optional services?

The staff indicated that no major changes are expected in coverage of optional services. There has been some talk of coverage of psychological services and of occupational therapy services. Changes in state law, however, would be necessary.

c. Are copayments being imposed? If so, at what level and on what services?

No copayments are imposed under the Nebraska state plan. The staff indicated that copayments are not viewed as a feasible means of controlling either costs or utilization. Nebraska strongly supported the changes in HR-1 to make copayments optional rather than mandatory during the 1972 debates.

d. Is prior authorization being imposed?

A variety of services are subject to prior authorization. These procedures are described in the Provider Manuals. They include procedures of unproven value, established procedures of questionable current usefulness, and procedures which tend to be redundant when performed in combination with other procedures.

Inpatient services do not require prior authorization except for those special procedures expressly described in the Provider Manuals. Dental services under $40 require no prior authorization. Between $40 and $200, county prior authorization must be obtained. For dental services more than $200 and for certain procedures, state prior authorization is necessary. All optometric services, except eyeglass repairs, require prior authorization.

Prior authorization requests are submitted on forms described in the Provider handbooks. (Dental and physician request forms are included as Nebraska-15 and -16.) As indicated, some prior authorization is done at the state level.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physician reimbursement under the Nebraska Medicaid program is the same as under the Medicare program. The Part B Medicare fiscal intermediary provides the state with tape-to-tape exchange on customary fees. The state used to use the Nebraska RVS with reimbursement at $5.00 per unit. The present system, based on Medicare screens, is automatically updated when Medicare screens are updated. An RVS is still used for podiatrist services, however.

b. Are formularies for drugs being restricted?

Nebraska covers both legend and non-legend drugs. Legend drugs are reimbursable unless specifically excluded. Among the drugs that are specifically excluded are anti-obesity (anorexic) agents, experimental drugs, and more than a 3-months supply of birth control tablets. Over-the-counter drugs must have been prescribed by a licensed practitioner, be considered to be "real medical needs," and be considered to be effective by "general medical consensus." Personal care items and dietary supplements are excluded.

Some drugs that would be otherwise excluded can be reimbursed with prior approval. Thus, an anti-obesity agent which is to be utilized for the treatment of hyperkinesis or for narcolepsy can be prior authorized. In addition, although Nebraska applies MAC requirements to MAC drugs, a physician can indicate that a specific drugs is medically necessary for the proper treatment of his patient. (A copy of the Pharmacy Manual is included as Nebraska-17.)

As indicated, MAC and EAC requirements are applied in the Nebraska program. A dispensing fee is assigned to each individual pharmacy based on specific cost data obtained through a survey. The staff indicated that these dispensing fees vary considerably.

The state utilizes a lock-in for approximately 200 Medicaid beneficiaries. Such beneficiaries are "locked-in" to both a physician and pharmacy and sometimes to a hospital as well. The staff indicated that the state is reimplementing lock-in on an automated basis.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

   a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Nebraska has a program of catastrophic coverage for families with children. This program is handled as emergency assistance with 25 per cent county funds, 25 per cent state funds and 50 per cent federal funds. Medical assistance is disbursed as a vendor payment. Two criteria are applied under the program. There must be a child in the family, and the county must be willing to pay its 25 per cent share. There are approximately 50 cases per year with disbursements of approximately $65,000. In two-thirds of the approved cases it is the child who incurs the medical expenses.

Nebraska also has a general assistance program. This program is county administered, and provides for medical expenses in some cases. Generally, this is treated as a one-shot proposition, with eligibility usually based on an accident, for example.

   b. What are the sources of care for medically indigent adults? How many receive services? A what cost?

In addition to the above services, there are a number of public hospitals in Nebraska. There are 7 city, 27 county, and 8 district hospitals. Most of these public hospitals operate pretty much as private hospitals. There is no automatic eligibility for indigents. The staff indicated, however, that significant services are provided to indigents and are written off as bad debts.

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

New Hampshire increased its optional supplement level for SSI beneficiaries from $203 to $216 for an individual, and from $284 to $302 for a couple, effective July 1, 1978. These levels were reached by applying the 6.5 per cent federal cost-of-living increase to the state supplement as well. These benefit levels are also used for determining 209(b) eligibility. Increases pursuant to state law are implemented automatically every July 1. (See New Hampshire-1.)

AFDC levels have not increased since before 1969. (See New Hampshire-2.) Medically needy levels, set at approximately 110 to 115 per cent of AFDC standards, have also not increased since at least 1974. (See New Hampshire-3.)

   b. Are states changing resource criteria?

Resource levels for all categories of medically needy are set at $2,500 for an individual, $4,000 for a couple, and $100 for each additional person. AFDC cash assistance resource limits are set at $500.

A home and car are completely exempt for all programs.

A transfer of property prohibition is applied across--the-board in the New Hampshire program. It is a 3-year prohibition with an intent requirement. The staff indicated that in practice the burden is placed on the agency. (See New Hampshire-4.)

In a situation in which one spouse becomes institutionalized, his/her share of the home is treated as a joint resource which is inaccessible for utilization. Resource levels have been unchanged since 1972.

   c. Is "Ribicoff children" option being used for some specific groups of children or all children?

New Hampshire provides Medicaid for financially eligible individuals under the age of 21 for whom public agencies are assuming full or partial financial responsibility and who are in foster homes, private child-caring institutions, or in subsidized adoptions. The staff indicated that additional categories of "Ribicoff children" will not be aided unless mandated by federal law.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are not covered under either the Medicaid or AFDC programs. The state does pay for deliveries, however, and payment for pre-natal care is included within this reimbursement when billed as total OB care. The staff indicated that it is unlikely that coverage will be expanded.

e. What is status of coverage of AFDC-UF families?

Families with unemployed fathers are not covered under either the AFDC or Medicaid programs in New Hampshire.

f. Are states proposing changes in operation of spenddown?

The major recent change in the administration of the New Hampshire spenddown program was an abandonment of the 1-month accounting period in May. The staff indicated that the 1-month accounting period was disastrous for administration.

The other main change being considered is the inclusion of intermediate care facilities. Presently, intermediate care facilities are not a covered service under the medically needy program. Thus, an individual in an intermediate care facility is subject to the 300 per cent cap in order to qualify as categorically needy. Such an institutionalized individual could qualify for other services, however, if financially eligible.

If an individual has income less than the nursing home cost and less than the 300 per cent cap, then this is treated as an ongoing eligibility situation. It is not subject to the "in and out" characteristic of the New Hampshire spenddown program.

g. What are states doing with regard to 209(b) option?

The staff indicated that New Hampshire has no intention of abandoning the 209(b) option. New Hampshire continues to apply a more restrictive disability standard than under SSI. Disability must be permanent, not merely expected to last 12 months. Disabled children are also not included.

More restrictive income standards are also applied. For the aged and disabled, earned income is only disregarded to a maximum of $50.00 (the first $20 plus 1/2 of the next $60 up to $30). Blind recipients have an earned income disregard of $85 plus 1/2. In addition, individuals with unearned income receive a $13.00 disregard. For couples this disregard is increased to $20.00.

The staff indicated that the desire to be a 209(b) state does not merely stem from a desire to control costs. Rather, it also represents a desire to have control over the program.

2. Compare use and operation of spenddown provision among states.

   a. Are states changing income lines or operation of spenddown?

As indicated, income criteria were raised under the 209(b) program effective July 1, 1978. Income criteria for the medically needy continue to fall further and further behind. The only major change in operation was the change from a 1-month to 6-month accounting period.

   b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

The 209(b) spenddown and the medically needy spenddown are administered identically.

   c. What groups use the spenddown provision? How is public informed about spoenddown provision?

The New Hampshire Medicaid agency does prepare some pamphlets for distribution. (See New Hampshire-5.) Some individuals learn about the spenddown program when they become financially ineligible for cash assistance. Others are referred by institutional providers.

d. How is spenddown administered?

New Hampshire uses a 6-month accounting period. A separate retroactive eligibility period is used for the 90 days prior to the date of application.

The staff described the spenddown program as the "in and out" program. This name arose because during the time that a 1-month accounting period was used, individuals were constantly entering the program and going out of the program during the same month.

Form 62 (included as New Hampshire-6) is used for listing medical bills. The medical bills are brought in to an eligibility technician who tries to encourage the client to bring the bills in chronological order. This may not always be done so some back-dating of eligibility is done where necessary.

Where an individual bill meets and surpasses the spenddown liability, the New Hampshire agency initiates coverage including that bill for reimbursement. Actual incurred expenses are used rather than Medicaid reimbursement rates. Uncovered services are included in satisfying the liability. Eligibility begins at the point that the liability is met. Bills for that date of service are split; other bills are covered beginning on a specific date.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

Psychiatric and psychological services are limited to $500 per fiscal year. Chiropractic services are limited to 24 calls per fiscal year. Podiatrist services are also limited to 24 calls per fiscal year. Doctor visits in long-term care and inpatient settings are also limited as well as EPSDT screenings.

No other major limits exist in the program and none are being contemplated.

b. What changes are anticipated in coverage of optional services?

No major changes are expected in expansion of services. Reductions due to budget constraints are possible. The

Governor has directed the department to prepare a budget at the same fiscal level as last year. In light of inflation, a number of alternatives are being considered to make up the deficit. The staff indicated that the medically needy program is being considered for elimination. The legislature will have to decide this issue. The state has had a medically needy program since 1968. The staff explained that the legislature was likely to overturn the Governor's directive.

Some consideration is being given, as indicated, to the establishment of intermediate care facilities as a covered service in the medically needy program. The staff has also requested reinstatement of the adult dental care program which was removed in 1975. This program is presently limited to treatment for relief of acute pain and/or elimination of acute infection and x-rays that are single films of the involved areas. The staff indicated that in light of budget constraints it is unlikely that this program will be reinstated.

c. Are copayments being imposed? If so, at what level and on what services?

No copayments are presently being imposed under the New Hampshire Medicaid program, but there is some consideration of them as a cost-containment alternative.

d. Is prior authorization being imposed?

A variety of services are subject to prior authorization. Inpatient days beyond PSRO limits, out-of-state services, long-term care placements, physical therapy of more than 10 visits, occupational therapy and speech therapy of more than 5 visits, dental services of more than 1 extraction or the start of therapy of more than $150, private-duty nursing, durable medical equipment in excess of $100, and some vision care services are subject to prior authorization. Requests for prior authorization (a copy is included as New Hampshire-7) are submitted to the central office for review by the medical services consultants. These requests are often processed over the phone and turnaround time hardly ever exceeds 1 to 2 days. Recipients are notified of denials, but do not receive information of their fair hearing rights.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physician reimbursement is made on the lower of individual profiles or the 75th percentile of area profiles or actual charges. Individual profiles are based on 1971 charge data, as are area profiles. The staff indicated that a statewide fee schedule is being prepared. The low fee levels, not updated since 1971, have caused problems with physician participation. In addition, physicians who have entered the program since 1971 are paid based on the area profile which may be higher than individual profiles. The staff indicated that the National Association of Blue Shield Procedure Codes is being used for describing services subject to the fee schedule.

b. Are formularies for drugs being restricted?

New Hampshire does not utilize a formulary for legend or non-legend drugs. Legend and non-legend drugs are reimbursed at the billed usual and customary charge or at the MAC or EAC cost plus the dispensing fee, whichever is less. Effective November 1, 1978, this dispensing fee will be increased to $2.70 (from $2.20).

Over-the-counter drugs are covered if prescribed by a doctor.

Anorexants are generally excluded from coverage. Vitamins are available for children under the age of 7. Some other vitamins are available for specific conditions.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

New Hampshire has no state-only programs for care of indigents.

b. What are the sources of care for medicaly indigent adults? How many receive services? At what cost?

Towns and counties administer a general assistance program which includes medical care. This is

administered through the county commissioners, selectmen, or through the overseer of the poor. No data was available on the expenditures for such services, but the staff indicated that expenditures are very limited.

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

A partial SSI pass-on was made effective July 1, 1978. Ordinarily, a cost-of-living increase would have been applied to both the federal SSI level and to the state optional supplement share. Only the federal pass-on was made this year because the judgment in a retroactive court case required a diversion of funds. (Benefit levels are described in New Jersey-4.)

A 5 per cent cost-of-living increase was also implemented in the AFDC program effective July 1, 1978. (The schedules of AFDC grants are included as New Jersey-1.)

   b. Are states changing resource criteria?

SSI resource standards are also used for the optional supplement program. AFDC resource standards exempt a house, a car less than $500, and funds set aside for the specific purpose of meeting an identified family need (including education, the downpayment on a home, an automobile purchase, and similar needs involving home furnishings and essential repairs). Up until July, 1977, a car could be of a value up to $1,200.

A 1-year transfer of property prohibition is applicable in the AFDC program. (This prohibition is set forth in New Jersey-2.)

   c. Is "Ribicoff children" option being used for some specific groups of children or all children?

New Jersey provides medical assistance for all financially eligible children under age 21 as "Medicaid specials." For children under 21 who are emancipated and living in the household or living outside the home, the AFDC schedule of 1 is used to determine financial eligibility.

   d. Are unborn children covered? Are there plans to change such coverage?

As of May 1, 1978, New Jersey began aiding unborn children upon medical verification of pregnancy. Only

Medicaid coverage is provided. Such recipients are not included in the AFDC program.

e. What is status of coverage of AFDC-UF families?

New Jersey provides AFDC and Medicaid to children deprived of parental support or care by reason of the unemployment of the father. The federal definition of employment is used. In addition, however, AFDC is provided to under-employed families as well. These recipients are referred to as AFDC-N. (See New Jersey-3.)

f. Are states proposing changes in operation of spenddown?

New Jersey does not have a spenddown program. A very limited (3,000 person) demonstration project in Newark has been approved by HEW, but no spenddown procedures have been developed. The Newark project is the prototype for an HMO serving a Medicaid waiver population whose incomes fall between 100% and 133 1/3% of the current AFDC guidelines. A premium payment is charged for enrollees using a six-month enrollment period.

Pressure has been building for the establishment of a medically needy program. The past 2 sessions, the New Jersey Assembly has passed a medically needy bill. On each occasion, the State Senate has rejected it.

New Jersey also does have a 300 per cent cap program for nursing home residents.

g. What are states doing with respect to 209(b) option?

New Jersey is not a 209(b) state and has no intention to elect this option.

2. Compare use and operation of spenddown provision among states.

New Jersey does not have a spenddown program.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

New Jersey has finally restored most of the cutbacks made over the past few years. Fiscal 1976 was a disastrous year for the New Jersey Medicaid program. In August, 1975, all practitioner fees were reduced by 10 per cent. A 40 per cent cut was made in lab fees. The prescription dispensing fee was cut by $.25; a copayment was imposed

of $.25 on prescription drugs although other services were also considered. Over-the-counter drugs were eliminated except insulin supplies and family planning supplies. More restrictive standards were placed on orthodontia and replacement of eyeglasses.

In January, 1976, adult dentistry was eliminated as were therapy services, medical supplies and equipment, podiatry services, chiropractic services, psychology services, hearing aids for individuals over age 21, optical appliances for individuals over age 21, and a reduction was made in inpatient rates. These were challenged in court cases.

In March, 1976, after a supplemental appropriation, all cuts were fully restored except the 10 per cent cut in practitioner fees and the reduction in hospital rates. Copayments were also lifted.

In January, 1977, the dispensing fee was restored for pharmacists to $2.05. A $.10 increment was also authorized for 24-hour service. Effective January 1, 1978, the basic fee was increased to $2.20. Effective February 1, 1978, an add-on of up to $.30 was implemented for specified extra services. The 10 per cent reduction in provider fees was also restored. Only lab fees continued at the reduced level.

b. What changes are anticipated in coverage of optional services?

No major changes are anticipated in coverage of optional services. The staff expressed some concern about the possible effect of a Proposition 13-type measure in fiscal year 1980.

Home health services were liberalized in December, 1976. Three levels of care were established. Staff indicated that impact is limited due to the absence of a medically needy program and the low income standards. This problem is compounded by the extreme shortage of ICF beds.

c. Are copayments being imposed? If so, at what level and on what services?

Copayments are not presently being imposed on any service, and there is no present intention to re-institute copayments.

d. Is prior authorization being imposed?

Prior authorization is imposed on long-term care placements, elective cosmetic surgery, psychiatric services by a psychiatrist, psychologist or in a clinic beyond $300 per year, some optometric services, orthotic devices by podiatrists, non-routine dental services, home health services, therapy services, non-emergency transportation, durable medical equipment exceeding $30 in value, and medical day-care services. Prior authorization is also required for anorectics, injectables administered out of the practitioner's office, and protein replacement products.

Prior authorization is usually performed by state offices at a local level. These offices are staffed with doctors, nurses, dentists, pharmacists, and social workers. Providers usually make a request for authorization in writing. (Copies of the prior authorization request form for optical appliances and transportation are included as New Jersey-5 and New Jersey-6, respectively.) In long-term care cases, a nurse is actually sent out of the office to evaluate the level of care.

Some requests, including optometric and podiatric requests are handled through the central office in Trenton. Prior authorization requests are usually processed within the same week. There are no promulgated guidelines, but some internal guidelines are used by consultants to determine medical necessity for authorization. The staff indicated that consultation is usually initiated before any denial of prior authorization. The fair hearing process is available to both providers and recipients. Most hearings in long-term care after a change in condition occur with the level of care continued until adjudication. (A copy of the long-term care denial notice is included as New Jersey-7. A copy of the general denial notice is included as New Jersey-8.)

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

   a. Are physician fees being limited?

As indicated, physician fees have only recently begun to be restored. A 5 per cent increase was made in physician fees in 1974. A 10 per cent reduction was then imposed in 1975. With the restoration of this cut, present physician fees are equal to 1970 levels plus 5 per cent. As a result, the staff indicated that provider participation in the program is a serious problem.

b. Are formularies for drugs being restricted?

The New Jersey program covers both legend and non-legend drugs. Some drugs such as anorexics require prior authorization. A lock-in is being implemented effective September 1. Some drugs are limited to a 60-day maximum supply plus 2 refills within a 6-month period. Birth control pills may be filled for a three ovulatory cycle and may be refilled twice within nine months. Vitamin combinations may be dispensed in 100's and refilled twice in one year.

Pharmacies are paid a percentage of the average wholesale price plus a dispensing fee, less a discount ranging from 2% to 6% based on prescription volume. Institutional pharmacies are paid at 75% of the rate of retail pharmacies.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

New Jersey has a program of medical assistance for the aged funded by the state. This is really a remnant of the old Kerr-Mills program. Income standards have not been changed since 1963. Hospital, nursing home, and home health services are provided. Income standards used to be higher than SSI standards but they are now significantly lower.

The medical assistance for the aged program provides the Medicaid scope of services. Because of the low income levels, the majority of assistance under the program goes to non-institutionalized individuals who need home health services and who have incomes over the SSI levels and provides legend drugs, insulin, and insulin supplies for individuals 65 years or older who are income-eligible, but are not covered by Medicaid or other insurance. In the month of April, 1978, 267 recipients out of 390 eligibles in the program received services totalling $27,120.

The State also operates a Pharmaceutical Assistance to the Aged program. Eligibility is limited to single persons with incomes under $9,000 and married couples with incomes under $12,000, who are over 65 and who are New Jersey residents. Eligible persons receive legend drugs and insulin and insulin supplies at $1.00 per prescription. As of October, 1978, more than 260,000

persons were enrolled in the program and enrollment was increasing.

In addition, municipalities in New Jersey operate a general relief medical assistance program. This is a vendor payment system administered by the Department of Public Welfare in each municipality with a responsibility for administering the GA program. The state matches local monies. Total costs for medical care in January, 1978, were $915,556 for 523 beneficiaries.

As indicated, New Jersey also provides AFDC and Medicaid for low-income working families. Children receive federal matching for Medicaid as Ribicoff children. AFDC-N adults totaled 5,455 in April, 1978. 2,387 adults received $219,772 in services in April, 1978 under this state-only program.

Statistical reports for January and April, 1978, are included as New Jersey-9 and New Jersey-10, respectively.

NEW MEXICO

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

New Mexico has no optional supplement program and very few mandatory supplement recipients left. As a result, an increase was only applied to the federal SSI benefit. SSI recipients in resident care facilities also receive an optional $45 supplement. There are approximately 200 such recipients. No increase was made in this optional supplement amount.

AFDC benefits are established at 96 per cent of 1972 standards of need. This percentage ratable reduction has varied. The last increase to 96 per cent occurred effective July 1, 1977. The grant computation process is described in form ISD 202-AFDC/GA (included as New Mexico-1).

   b. Are states changing resoure criteria?

New Mexico exempts a house and car. The last change in resource criteria was when a car was made exempt about 3 years ago. There is a $1,200 limit for non-exempt property. Certain other items are limited to specific values. Thus, the cash surrender value of a life insurance policy cannot exceed $550. If it does, it automatically makes the family ineligible. Liquid assets cannot exceed $750.

New Mexico has a 2 year rebuttable presumption transfer of property prohibition. An individual who has transferred property for less than fair market value within this period suffers a 2 year disqualification.

In the situation in which one spouse becomes institutionalized, a home occupied by the other spouse or dependent child is indefinitely exempted.

   c. Is "Ribicoff children" option being used for some specific groups of children or all children?

New Mexico aids the following subclass of "Ribicoff children": Individuals for whom public agencies are

assuming full or partial financial responsibility and who are in foster homes or private child-caring institutions.

d. Are unborn children covered? Are there plans to change such coverage?

Effective with the beginning of the fourth month of pregnancy, upon medical verification, unborn children are treated as an additional person in the family budget unit. Thus, a woman pregnant with her first child would receive a grant after the fourth month for AFDC as a family of two. This policy has been in effect for years and there is no plan to change it.

e. What is status of coverage of AFDC-UF families?

Families deprived of parental support or care by reason of the unemployment of the father are not eligible for either AFDC or Medicaid in New Mexico.

f. Are states proposing changes in operation of spenddown?

The only spenddown program in New Mexico is the 300 per cent nursing home cap. New Mexico had been applying this standard for eligibility in the first month of institionalization. HEW has indicated that eligibility must be based on the SSI need level for the first full month. The staff strongly opposes this approach since the nursing home will not want to take the beneficiary for the partial first month of institutionlization.

The staff also described problems with recomputing budgets during a particular month for additional unexpected expenses for uncovered services. Presently, the county office calculates recipient liability, notifies the nursing home and the Santa Fe central office, which then passes on the information to the fiscal intermediary. Eligibility is done on a month-to-month basis, but there is infrequent updating of information. Certification is based on a 12 month period.

There is no present prospect of a medically needy program in New Mexico. A medically needy program was proposed and defeated in the 1976 legislature.

g. What are states doing with regard to 209(b) option?

New Mexico has never been a 209(b) state and has no intention to become one.

2. Compare use and operation of spenddown provision among states.

New Mexico has no spenddown program for the medically needy or under section 209(b).

3. Identify and analyze current and potential benefit restrictions on Medicaid.

   a. What limits are being considered on amount of service?

Most limits on the availability of services under the New Mexico program can be waived with prior authorization. (An example of a prior approval form is included as New Mexico-2.) The staff indicated that limits are being considered on diathermy, and bio-feedback therapy. New Mexico had a limit of 30 days of inpatient hospital stay per calendar year. This was rescinded after 1 month. Limits are also being considered on eyeglasses, hearing aids, and chiropractic services on cross-over claims with Medicare.

   b. What changes are anticipated in coverage of optional services?

No additional optional services are expected to be added at this time; no existing services are expected to be deleted. Home health services are limited to Title XVIII certified agencies. There are 12 certified rural health clinics already in New Mexico. Two additional applications are pending.

   c. Are copayments being imposed? If so, at what level and on what services?

New Mexico presently imposes a copayment of $.25 per prescription drug and $2.00 per visit on dental services. The staff indicated that this has had no significant effect on utilization. The copayments apply to institutionalized residents, but not to EPSDT beneficiaries. The staff indicated that mandating drugs as a service and eliminating copayments would not have a significant effect on the New Mexico program.

The staff indicated a preference for maintaining the dental copayment. The staff indicated that the presence of the copayment, however, did not have a significant effect on allowing passage of this provision.

d. Is prior authorization being imposed?

A wide variety of services are subject to prior authorization in New Mexico. These include psychiatric services beyond a 3 hour evaluation. Physical therapy and related services, durable medical equipment, dentures and all other non-emergency dental services, podiatrist services, certain prescribed drugs, and eyeglasses more frequently than 1 pair per 2 year period. All prior authorization except for non-legend drugs is performed by the New Mexico PSRO. The performance of the PSRO is viewed as improving. The staff indicated some problems for the PSRO because of the mixed signals from Washington regarding quality assurance and cost-containment.

There is no notification of the beneficiary when a request for prior authorization is denied. The beneficiary must be notified through the provider. Turn-around time for prior authorization requests by the State is approximately 2 days. The PSRO generally advises the provider within 2 weeks.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

New Mexico uses the 1969 California RVS with some updating. Usual and customary charges have been updated to the 1977 profiles. Reimbursement is based on the lower of actual charges or usual and customary charges. Previously, there had been some problem with physician participation since prior to the most recent update, the state had used 1974 profiles.

b. Are formularies for drugs being restricted?

New Mexico covers most legend and many non-legend drugs. Non-legend drugs require prior authorization from the central office. Some legend drugs require prior authorization by the New Mexico PSRO. Physicians file a request for coverage. Anorexants for obesity therapy and hypnotics such as quaaludes are excluded without prior authorization.

Most non-legend drugs (except insulin) which are approved are for vitamin supplements. Although theoretically available, the staff indicated that the state would probably not approve aspirin under prior authorization. (Covered drugs are set forth in New Mexico-3. This list is being revised currently.)

The dispensing fee for prescription drugs is now set at $2.65 and will probably go up to about $2.80.

There are some minimum dosages for maintenance drugs and some maximum dosages for other drugs. New Mexico utilizes a lock-in with the beneficiary selecting providers. There is a counseling component to this lock-in. Approximately 200 beneficiaries are presently "locked-in."

c. Miscellaneous.

The only controls applicable to hospital services are the health planning and PSRO and some state utilization controls. The state is attempting to limit reimbursement to outpatient hospital departments for prescription drugs by setting a maximum of $2.00. The staff indicated that they wanted to insure that beneficiaries would have access to emergency care, but that non-emergency prescriptions would be filled through a pharmacy. The staff indicated concern over unreasonable charges and the lesser documentation available in outpatient settings for utilization review.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

There is no general assistance medical care program in New Mexico. GA is state run but has only approximately 300 to 500 recipients on the rolls at any time. Some counties administer medically indigent programs which are funded by a sales tax. It is those counties that have medically indigent programs that are seeking a state medically needy program.

b. What are the sources of care for medically indigent adults? How many receive services?

The main source of treatment for individuals ineligible for Medicaid are the Indian Health Service for Indians and some county medical centers for other indigents.

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

New York provides an optional supplement to SSI beneficiaries. Effective July 1, 1978, New York passed on only the federal cost-of-living increase. This was due to the budget constraints in the state. (SSI benefit levels are included as New York-1.)

AFDC budget levels have been unchanged since at least June 30, 1977. AFDC budgets are determined by adding a basic needs allowance to a maximum allowance for shelter costs. The basic needs allowance is described as the PA level. (These levels are included as New York-2.) Maximum monthly shelter allowances are set forth in the regulations at section 352.3 (included as New York-3).

For some individuals, the cash assistance level is higher than the medically needy level. This has resulted because of the high shelter allowances in some counties, whereas the medically needy level is computed on a statewide basis. In Suffolk County, for example, the PA level for a family of one person would be $299 ($205 plus $94). The medically needy level is $258.

This has resulted in a compliance issue. The HEW regional office has indicated that the state can go to regional medically needy levels. The state is therefore considering a change in its income criteria due to this compliance issue. Presently, there are several medically needy levels in the state. This occurs because the higher of the public assistance or medically needy level is used. HEW has said that this violates statewideness.

Medically needy protected income levels for 1, 2, and 3 person families increased effective July 1, 1978. Protected income levels for 1 and 2 person families increase each time SSI levels are increased. Protected income levels for families of 3 have been increased to stay ahead of the protected income level for a family of 2. Medically needy levels for families of 4 and above have been unchanged since 1976. (The trend in income levels is described in New York-4.)

Medical assistance for individuals aged 21 to 65 and not categorically linked is available under a state-only program. These individuals must meet general assistance cash requirements. There is no spenddown, however.

b. Are states changing resource criteria?

Resource levels for the medically needy are determined by adding one-half of the protected income level plus $500 per person up to a maximum of $2,000 per household. Thus, for a medically needy individual, the resource level is $2,050. This is computed by taking 1/2 of the protected income level of $3,100 (equals $1,550) and adding to that $500 for the 1 person in the family. This formula is contained in state statutes. As a result, resource levels for the medically needy increase each time protected income levels increase.

A home is exempt for SSI beneficiaries, medically needy individuals and AFDC recipients. In theory, a lien against the home is possible under state law for AFDC and Home Relief recipients. No comparable provision exists for medically needy households.

New York has a transfer prohibition applicable to all medical assistance beneficiaries. A state law was passed on June 24, 1978, effective August 24, 1978. (See New York-5.) It establishes a prohibition on all transfers within 18 months of applying for assistance. In theory, the staff indicated, transfers prior to that period can be reviewed to determine if adequate consideration was obtained and if the transfer was made for the purposes of qualifying for medical assistance. An individual who violates the transfer prohibition is disqualified for MA until the value of the resource is recovered and utilized for medical care or other necessary client expenses.

In a situation in which one spouse becomes institutionalized, the state continues to exempt the value of the home if occupied by the institutionalized spouse except for the temporary absence, or if it is maintained by him/her, or if it is occupied by a spouse or child.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

New York provides Medicaid for all financially eligible individuals under the age of 21. This is somewhat confusing in the state plan which specifically describes coverage for children in foster care, for example. This is due to a state law which did not authorize coverage for children in foster care previously. Financial eligibility is based on either the protected income levels or PA levels whichever are higher.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are included in both the state AFDC and Medicaid programs. Presently, eligibility for AFDC and Medicaid begins at the beginning of the 4th month. The unborn child is treated as an additional person in the family budget unit for grant computation purposes.

The staff indicated that for Medicaid in the first trimester, the unborn is treated as a "Ribicoff child." Eligibility can therefore be provided even for intact families in the first trimester. After the first trimester, eligibility exists as a AFDC-linked family based on the incapacity of the mother.

e. What is status of coverage of AFDC-UF families?

New York provides AFDC and Medicaid to families with unemployed fathers based on the federal definition. Families who do not meet the federal definition, but who have income under the PA levels, qualify for home relief.

f. Are state proposing changes in operation of spenddown?

No major changes are planned in the operation of the spenddown program. The staff described great difficulties in administering the program. Despite requests for assistance to HCFA and other states, staff indicated that no viable systems have been received.

g. What are states doing with regard to 209(b) option?

New York is a 1634 state and has no interest in the 209(b) option.

2. Compare use and operation of spenddown provision among states.

   a. Are states changing income lines or operation of spenddown?

As indicated, there have been some increases in income criteria under the spenddown program. No other changes are expected, although there are some compliance problems in New York's administration.

   b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.

New York is not a 209(b) state.

   c. What groups use the spenddown provision? How is public informed about spenddown provision?

The staff indicated that some outreach is conducted. Mostly this is done through provider education. Providers then pass on eligibility information to their patients. The state also operates an 800 number as a hotline for all services. Some additional outreach is conducted through the Administration on Aging. In addition, when an individual is denied cash assistance eligibility, they are advised of the medically needy program and of the spenddown provision. This is mandated under state law. Cash recipients are also usually advised if discontinued because of excess income.

   d. How is spenddown administered?

New York uses a 1-month spenddown for ambulatory care. A 6-month spenddown is used for inpatient care. The staff indicated that this longer period is based on the recognition that hospitals will often allow the beneficiary to pay the spenddown over time. For long-term care cases, the patient retains $28.50 for personal needs.

In some counties, beneficiaries with small ambulatory care spenddowns are allowed to pay the Medicaid agency directly. The staff indicated that such beneficiaries usually have liabilities of $30 to $40 per month. Cards are then issued each month automatically.

This program has been implemented in Suffolk, Onondoga, and Tioga counties. The agencies view this as simply payment of a premium. The staff indicated that these counties do monitor to see if the client has expenses which at least exceed the premium.

Other counties utilize paid expenses in most cases. The staff indicated that otherwise, state systems are not sophisticated enough to insure that reimbursement is not made for bills that have been used to compute the individual's liability. Some counties do use incurred expenses. The staff indicated that with the present system, incurred expenses cannot work except for inpatient hospital bills. These are easy to monitor to insure that payment is only made once. Liability is simply assigned to a specific hospital.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

    a. What limits are being considered on amount of service?

No non-waiveable limits are imposed on services under the New York plan. There is no coverage for experimental services (unless recognized in the profession) or for cosmetic services (although a case was recently lost on transsexual surgery).

    b. What changes are anticipated in coverage of optional services?

New York includes nearly all services in its Medicaid program. Chiropractic and podiatrist services were excluded last year. The staff indicated that this was due as much to fraud and abuse in the program as to fiscal concerns. The staff described problems with a number of "bad actors" in the program. No change in scope of optional services is expected.

    c. Are copayments being imposed? If so, at what level and on what services?

No copayments are presently being utilized in the New York Medicaid program. A statute still is on the books imposing copayments on specified services.

Copayments were limited to individuals under the age of 61. This raised problems with comparability for Medicaid recipients over the age of 61. In addition, because the state could not identify EPSDT services (upon which copayments could not be imposed), all services for individuals under the age of 21 were exempt from copayments and were treated as EPSDT services. The staff indicated that they view the lock-in available under MMIS to be more effective in controlling utilization than copayments. There is no present intention to reimpose copayments in New York.

d. Is prior authorization being imposed?

Prior authorization is imposed on a variety of services. Authorization must be obtained from the Local Health Professional (formerly the Local Medical Director). Prior authorization is under the jurisdiction of the Health Department.

Prior authorization applies to such vision care services as contact lenses, and to such dental services as orthodontia. Durable medical equipment over a $40.00 limit is subject to prior authorization. (A copy of a request form is included as New York-6.)

The staff indicated that turnaround time for requests varies greatly. The staff indicated that this does not impose a serious problem since only non-emergency services are subject to prior authorization. When a request is denied, there is no notification to the beneficiary; notice is only sent to the requesting provider.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physician services are reimbursed based on the 1965 New York RVS (which is based on the 1964 California RVS). The RVS describes units of service, with some modifications. In addition, the state uses some CPT-4 for coding. Medical services are reimbursed at $5.00 per unit. Surgical services are reimbursed at $4.00 per unit, and anesthesia services are reimbursed at $5.00 per unit. This was last updated effective April 1, 1974. In 1969, fees were changed back to 1966 levels. This represented a 20 per cent reduction to $4.00 per unit for medicine and anesthesia, and $3.20 for surgery. A 25 per

cent increase to the present levels was implemented in 1974. Thus, fees are at 1969 levels.

The staff indicated that provider participation is not a serious problem in the program. They indicated that the key question for provider participation is promptness of payment. The fee level is not as significant. The staff supported the notion of statewide fee schedules and criticized the use of usual and customary charges as cost-ineffective.

b. Are formularies for drugs being restricted?

New York utilizes a formulary called the Commissioner of Health's Reimburseable Drug List. However, if a drug is not listed on the formulary, a provider can still seek prior authorization from the health department. This prior authorization would be requested by the physician. Various forms are used for requesting coverage depending on the locale of the patient.

Although MAC is utilized in New York, the state sets its prices for all drugs in the formulary which may be lower than MAC. These prices, previously established by a contractor, will be based on a tape-to-tape exchange between drug wholesalers and the state. The state removes the highest price and the lowest price and averages the remainder with a manual review by a state pharmacist for anomalies.

Dispensing fees are presently at $2.60. Until April 1, New York City fees were $2.00, and upstate fees were $1.80. From April 1 to July 1, fees were set statewide at $2.30. The $2.60 dispensing fee was implemented effective July 1. This change was made after a boycott by some pharmaceutical associations. A survey was conducted to set the dispensing fee. The staff indicated that the survey results were statistically invalid because of a low response rate.

c. Miscellaneous.

Hospital rates for Medicaid, Blue Cross, and some private carriers are set under state law by a rate-setting commission. Presently, any fee may be charged private payers. A new law that has been enacted will control private-pay rates as well.

Nursing home rates are reimbursed on a cost-related basis with an additional increment or tier for quality incentives.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

   a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

New York provides Medicaid eligibility for home relief recipients. The same scope of services as for Medicaid is provided. Resource limits are somewhat more restrictive than for the other cash assistance programs.

New York also operates a catastrophic illness program. These are individuals not otherwise eligible for Medicaid who receive coverage for inpatient care. The state will pay for the portion of the cost of inpatient care which, after application of insurance benefits and non-exempt resources, exceeds the lesser of (1) 25 per cent of the applicant's annual net income; or (2) the difference between the applicant's annual net income and the applicable public assistance income eligibility level.

During the past fiscal year, $235,878,871 were expended by the State of New York for medical assistance where no federal financial participation was available.

   b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

A variety of public hospitals and clinics are available to provide services to indigents. Because these programs are administered through a different agency, no cost data were available.

OKLAHOMA

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Oklahoma increased its maintenance standards for adult aid categories and for children effective April 1. The increase was $5.00 per person. This was also the increase in the personal needs allowance for an individual receiving care in a nursing facility. Adjusted grant levels are included as Oklahoma-1.)

Medically needy maintenance standards are set at 133-1/3 per cent of the AFDC payment level and they were increased accordingly effective April 1, as well. (Medically needy levels are included as Oklahoma-2.) The spenddown eligibility for institutionalized persons is based on a personal needs allowance of $55.00.

   b. Are states changing resource criteria?

Oklahoma is a 209(b) state. Although somewhat more restrictive income criteria are applied, resource limits are significantly lower than under the SSI program. On January 1, 1974, the market value of a home could not exceed $12,000. Other resources, including a car, could not exceed $350 for an individual or $500 for a couple. In addition, an individual could have up to $1,000 in a burial policy. These resource limits have been significantly updated over the years.

Effective November, 1977, equity, rather than market value, of the home could not exceed $20,000. A 40 acre limit was also still applied. The staff indicated that it was unlikely that Oklahoma would completely exempt a home. Cash resources are limited to $500 for an individual or $750 for a couple.

AFDC resource limits top out at $850 for a family of 7 or more. Total resources for the aged, blind, and disabled may not exceed $1,500 for an individual or $2,250 for a couple or family. This maximum includes a burial policy. However, the value of the burial policy cannot exceed $1,100. A more liberal standard is applied for the medically needy in that in addition to these resources, a medical needy individual or family may own a car worth up to $2,000 equity value.

Oklahoma has a 5-year transfer of asset prohibition. An individual who transfers an asset without commensurate

return is disqualified from receiving assistance for a period of five years from the date of the transfer. (A copy of this policy is included as Oklahoma-3.)

In the situation in which one spouse becomes institutionalized, Oklahoma continues to exempt a home if it continues to be occupied by the other spouse or minor dependent child.

The staff indicated that these narrower resource limits significantly control costs and they are reluctant to see an abandonment of the 209(b) option. In any case, they are not anxious to have the Social Security Administration making claims determinations.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Oklahoma provides Medicaid for all financially eligible children under the age of 21. Financial eligibility is based on the medically needy standard. Children with incomes over the standard may spenddown.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are not covered in either the state AFDC or Medicaid programs. A woman pregnant with her first child who is over the age of 21 therefore has no linking to the Medicaid program. The staff indicated that this does not pose a problem in obtaining pre-natal care since reimbursement for the delivery charge includes reimbursement for pre-natal care. A doctor will therefore provide pre-natal care pending reimbursement on the delivery. The staff indicated that no change is expected in this provision.

e. What is status of coverage of AFDC-UF families?

Coverage of families with unemployed fathers was eliminated from the state AFDC and Medicaid programs in 1975 as a budget measure. The staff indicated that it was a relatively small program anyway with only approximately 69 cases.

f. Are states proposing changes in operation of spenddown?

No major changes are anticipated with regard to administration of the Oklahoma spenddown program. Oklahoma has had a spenddown since at least January of 1966. Some changes are being made to tighten up administration. A computerized system will be used for processing spenddown eligibility and to assure that the state is not reimbursing providers for claims used in calculating the beneficiary's liability.

g. What are states doing with regard to 209(b) option?

Oklahoma has no intention of abandoning the 209(b) option. As indicated, resource standards are significantly more limited than under the SSI program. In addition, in determining eligibility, Oklahoma does not apply the income disregards applicable to the SSI program.

2. Compare use and operation of spenddown provision among states.

a. Are states changing income lines or operation of spenddown?

As indicated, Oklahoma has increased its income lines for the spenddown program.

b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

The staff indicated that Oklahoma does not administer the program as if a spenddown provision exists under the 209(b) option. Staff indicated that this is not necessary because of the State standard of need.

c. What groups use the spenddown provision? How is public informed about spenddown provision?

No outreach efforts are conducted by the state to inform potential eligibles of the program. Instead, the state depends on notification of beneficiaries by institutional providers. Applications for eligibility are then processed.

d. How is spenddown administered?

Oklahoma uses a monthly accounting period for its spenddown program. In many ways, the Oklahoma program is better administered than other programs. In addition, the staff indicated a minimum of problems in administering the program. This is in sharp contrast with most other states.

Once an individual applies for spenddown eligibility, the worker calculates the spenddown liability manually. The applicant is told to bring medical bills once this liability is incurred. Spenddown eligibility is explained through a form MS-MA-8 (included as Oklahoma-4) after the worker computes liability on a form MA-2 (included as Oklahoma-5).

Once an applicant has incurred expenses equal to or exceeding the liability, the worker completes the bottom of form MS-MA-8. On this form, the county worker requires the beneficiary to name the providers who will be directly reimbursed by the claimant. In this way, both the state and provider know which bills will be covered and which bills will not be covered. Form MS-MA-4 is then issued from the county office.

By administering the spenddown program in the described manner, both the beneficiary and provider have a clear indication of their rights and responsibilities under the program. The staff indicated that this has resulted in a high provider acceptance and participation in the program.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

Oklahoma imposes a variety of limits on scope of services. A $1,000 limit per patient per physician per day is imposed under the program. The staff indicated that this designed to limit the cost of medical care. In addition, a $40,000 limit per beneficiary per single disease is imposed under the program.

The $1,000 limit was effective November 26, 1968 and the Medical Care Advisory Committee has repeatedly refused to raise it. The $40,000 limit was originally $10,000 per single disease when it was imposed effective November 26, 1968. It was increased to $20,000 effective July 18, 1974, and then was raised to the present limit effective October 20, 1977.

A 10-day limit is imposed on reimbursement for inpatient hospital services. Individuals who need inpatient services beyond the initial 10-day period may attempt to qualify under the catastrophic illness program. This is also a Medicaid program, however, the staff indicated that decisions are not based solely on medical necessity. For individuals who have been discharged from a hospital, a new 10-day period starts after 20 days. The staff indicated that this 20-day period can sometimes be waived. The twenty day limit is not imposed for treatment of proven malignancy.

Other limits include 4 physician visits per month (with a waiver possible for acute physical injuries), 12 home health visits per year, and 3 prescriptions per month. Home health services must be prescribed by a doctor. Those individuals obtaining approvals from the Medical Evaluation Unit may qualify for services under the Non-Technical Medical Care Program.

Laboratory services are also extremely limited. X-rays are compensable after physical injuries. Oklahoma buys-in for individuals who receive a money payment from the Department and who are eligible for Medicare.

A copy of the Physician and Hospital Manuals is included as Oklahoma-6.

b. What changes are anticipated in coverage of optional services?

No major changes are expected in the scope of services in the Oklahoma plan. The Medical Care Advisory Committee has indicated a desire to expand coverage for supplies and durable medical equipment so long as there is no significant cost effect on the program. Rural health clinic services are restricted because a doctor can only supervise 1 physician extender in Oklahoma. There are no certified clinics yet.

c. Are copayments being imposed? If so, at what level and on what services?

No copayments are presently imposed in the Oklahoma program. The staff described copayments as an "administrative monstrosity" which "would deprive some people of needed services."

No formal lock-in is used in the Oklahoma program. Instead, informal counseling is used. The staff indicated that they felt this was far more effective.

d. Is prior authorization being imposed?

No prior authorization is employed in the Oklahoma Medicaid plan except for non-emergency medical transportation. The staff indicated that individuals either need services now or the service is not within the covered scope. Even catastrophic illness extensions are done on a post-service, pre-payment review basis.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physician services are reimbursed in exactly the same manner as Medicare. This is expedited by the fact that Oklahoma is also the fiscal intermediary for the Medicare part B program.

b. Are formularies for drugs being restricted?

Oklahoma does not use a formulary for prescription drugs. Instead, therapeutic categories are described. These are set forth in the Physician Manual. (Oklahoma-6.)

Medications are limited in dosages to a maximum of 100 units or a 34-day supply whichever is greater. Because of the 3 prescription limit, some counties supplement prescription drugs. This is discussed in Question 5a.

Drugs are reimbursed on the basis of MAC and EAC; a $2.50 dispensing fee is provided for retail pharmacies. Insulin and insulin supplies and family planning supplies are the non-legend drugs which are reimbursed under the program.

c. Miscellaneous.

Oklahoma has been relying on a voluntary effort to control hospital costs. There is no rate commission or prospective rate setting on the horizon.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

   a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

General assistance recipients are limited to a maximum payment of $35.00 per month. Oklahoma does not provide any medical care for this population. The staff indicated that this is one of the problems about being required to use the SSI definition of disability. Some general assistance recipients would have been covered under the old AABD program since the State formerly had a 3 month definition of disability.

For the Crippled Children's Program, a separate fund is established in each county by state law. No more than 1/5 of these funds may be spent on any one child in a year.

Several counties also operate pharmacies for Medicaid and non-Medicaid eligibles. For Medicaid-eligibles, these pharamcies supplement the drugs available under the state Medicaid program.

   b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to these sources of care, the state operates a children's hospital, a university hospital, and 3 psychiatric hospitals. The Children's Hospital is operated by the Oklahoma Department of Institutions, Social and Rehabilitative Services. University Hospital has a separate governing board. The three psychiatric hospitals are administered by the Department of Mental Health.

1. Analyze potential changes and trends in eligiblity criteria for Medicaid.

   a. Are states changing income criteria?

Up until July, 1977, Oregon reduced its supplement to the SSI payment by one-half of the SSI increase. Thus, only one-half of the cost-of-living increase was passed onto the beneficiary. This changed after the change in the federal law effective July, 1977. Presently, Oregon supplements SSI for the aged and disabled by $12.00, and supplements by $35.00 for the blind.

   b. Are states changing resource criteria?

Oregon has not made any changes in its resource criteria. It does use a 1-year transfer of asset prohibition in its AFDC program. This transfer of asset prohibition is also used for all other programs than SSI. Presently, the state agency must prove intent. A legislative change is being sought in order to presume intent for any transfer within one year. The staff indicated that this was due to the difficulty of demonstrating intent in such situations.

The one unusual feature of the Oregon system is that in the inter-spousal transfer situation (where one of two spouses enters an institution leaving the other spouse and/or a dependent child living in a home), the home continues to be exempt during the period of time that the individual continues to receive Medicaid. Oregon does impose a claim against the house upon its sale or death of the non-institutionalized spouse. A lien is not recorded, however.

   c. Is "Ribicoff children" option being used for some specific groups of children or all children?

The following "Ribicoff children" are being covered under the Oregon plan: (1) children for whom public agencies are assuming full or partial responsibility in foster homes or private child-caring institutions; (2) children in intermediate care facilities or receiving active treatment in psychiatric hospitals; and (3) children in an independent living situations with all or part of their maintenance cost paid by the Children's Services Division. In addition, some children who might be

eligible as "Ribicoff children" are aided under the state's GA-Medical Assistance only program. These are discussed in Question 5.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are included in the Oregon AFDC program and in the Medicaid program upon medical verification of pregnancy, but no sooner than the beginning of the second trimester. Eligibility calculations do not treat such unborn children as an additional member of the family budget unit. Instead, eligibility for a mother pregnant with her first child is computed on the basis of a 1 person family budget unit with a special diet supplement need added on.

e. What is status of coverage of AFDC-UF families?

Oregon includes unemployed fathers in their AFDC-UF programs. The federal definition of unemployment is used. In addition, the state provides coverage for non-federally eligible unemployed fathers as discussed in Question 5.

f. Are states proposing changes in operation of spenddown?

Oregon is not proposing any changes in the operation of its special medically needy spenddown program, although it would like to see an abandonment by the federal government of the incurred medical expenses approach. As discussed in Question 5, the state uses a different approach in its non-federally matched program.

g. What are states doing with regard to 209(b) option?

Oregon has always been an SSI state and has no plans on electing the 209(b) option.

2. Compare use and operation of spenddown provision among states.

a. Are states changing income lines or operation of spenddown?

The only spenddown program in Oregon is a section 1115 waiver in Multnomah County. This waiver is due to expire in February of 1979. HEW has indicated that it will be extended at least through the end of the state's present

biannium. This would end on June 30, 1979. Income lines are based on 115 per cent of the AFDC standard. Until recently, the AFDC standards had been increased once yearly in July. They are now increased in October and May.

b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

Oregon is not a 209(b) state.

c. What groups use the spenddown provision? How is public informed about spenddown provision?

No demographic characteristics were available. Most individuals learn about the spenddown program through institutional providers.

d. How is spenddown administered?

Individuals apply through the branch office of the State Department of Adult and Family Services. Once an individual demonstrates that his/her income is either below the maintenance need level, or that sufficient medical expenses have been incurred, the individual is certified for eligibility and referred to the county. The county office then explains the options for eligibility. Presently, there are three options available: (1) episodic or fee-for-service care; (2) enrollment in a health maintenance organization; and (3) enrollment in a medical insurance plan.

Although the waiver proposal projected a 20,000 person monthly average enrollment, only 2,300 individuals have enrolled on a monthly average basis. A 6-month accounting period is used for determining eligibility.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

No limits are presently being considered on the amount of services. There is a significant caveat, however. Ballot Measure 6 on the Oregon ballot would impose a tax limitation similar to Proposition 13 in California. The state agency has prepared a budget without considering the effect of possible passage of this proposal. If this measure passes, significant reductions in the amount of services might be possible.

Inpatient hospital services are limited to 21 days per person per fiscal year. This is an absolute cap and cannot be extended even in the case of medical necessity. The staff indicated that approximately 6 per cent of all medical stays go beyond this 21-day limit. The hospital must choose one of three alternatives at that point. Either the continuing stay will be treated as a bill for direct payment by the patient, or it will be treated as a bad debt, or it will be written off against the Hill-Burton obligation. Although there are two PSROs functioning in Oregon, the state is unwilling to abandon the 21-day limit.

While no absolute cap is applicable to home health services, these services are limited by being subject to the prior authorization process. Because of the requirement under prior authorization that services be both medically necessary and that there be money available, only limited coverage is given to home health services. The first priority for allocating available money is to people who would otherwise be in long-term care. Staff indicated that coverage does not go much beyond this first priority. In addition, the state has applied for a waiver to use Medicaid monies in Jackson and Josephine counties to reimburse homemakers, housekeepers, and adult day-care over a 4-year period. The state is awaiting formal approval.

b. What changes are anticipated in coverage of optional services?

No changes are being anticipated in coverage of optional services.

c. Are copayments being imposed? If so, at what level and on what services?

No copayments are presently being imposed. However, some thought has been given to the imposition of copayments on prescription drugs.

d. Is prior authorization being imposed?

Prior authorization is being imposed on such services as non-emergency adult dental care, durable medical equipment, podiatry, home health, physical therapy, transportation, and eyeglasses. A proposed service must meet two criteria in order to be approved. First, it must be determined to be medically necessary. Second, money must be available in that branch office and/or region to meet the cost of providing the service.

The determination of medical necessity is made either by a local medical consultant on contract with the state, or in the absence of such a medical consultant, by the state office directly. The determination of whether or not money is available is made in the branch, regional, or state office. Each branch office receives a portion of the appropriated funds on a pro-rata basis in the form of an allotment. This allotment may be transferred between branch offices and by the state office between regions. Thus, a medically necessary service might be denied or deferred because of a lack of money available. Allotment determinations are made on a quarterly basis.

Currently, there is no formal procedure for notification to the Medicaid beneficiary or to the provider of denials. This issue has been raised by HEW, and changes will be forthcoming. The provider sends in a request for prior authorization on Form AFS 405B (a copy of this form is included as Oregon-1). The provider is notified of the decision either by letter or by telephone, but does not receive formal notification or an explanation of appeal rights.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

   a. Are physician fees being limited?

Physician fees are reimbursed pursuant to legislative guidelines at 75 per cent of the 75th percentile of usual and customary charges. In July, 1976, reimbursement was increased to the 75 per cent level from 50 per cent. Charges are based on the 1969 California RVS with modifications for procedures not described under the RVS. These charges were last updated in July, 1977, by applying the CPI to the maximum fee level. A July, 1978 increase was requested in the budget and was approved by the legislature but was not implemented because of a projected deficit. The staff indicated that there is no significant problem with physician participation in the Medicaid program in Oregon.

   b. Are formularies for drugs being restricted?

Effective January 1, 1978, Oregon established an open formulary for prescription drugs. This formulary includes all drugs including anorexants. Except for diet supplements and insulin supplies, most over-the-counter drugs are not covered. Staff is considering some expansions in this area. Drug reimbursement is based on

MAC, where applicable, or on EAC. A professional dispensing fee of $2.70 is then added.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

   a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Oregon has several programs to provide services to non-Medicaid eligibles with 100 per cent state funding. One of these programs is the General Assistance Medical Program. This program provides basically the same scope of services as Medicaid, excluding psychotherapy and retroactive coverage. Financial eligibility is based on a maintenance need standard. This GA standard is calculated by using the AFDC standard and deducting the portions applicable to personal incidentals and household supplies.

Two classes of individuals are eligible for coverage. The program covers all categorical recipients of general assistance. These are primarily individuals who will be unemployable for at least 30 days and are financially needy. In addition, the state operates a medically needy spenddown program for its general assistance medical only population. This program covers such individuals as children living with non-needy caretaker relatives where the relative is meeting the cost of maintenance.

The GA spenddown is administered through a trust and agency account. If an individual has income under the GA standard, automatic eligibility is established. If an individual has income over the GA standard, the excess income is paid into an account maintained by the agency to reimburse itself. Approximately 500 cases (700 persons) are served under the GA spenddown program. This contrasts to 8,600 persons on the GA-categorical program. This equates to budget appropriations of approximately 14 million dollars for medical services for this population. Medical expenses will probably range between 15 and 20 million dollars.

Oregon also provides AFDC and Medicaid eligibility for families with incomes under the AFDC standards but who are working more than 100 hours per month. Families are treated as Medicaid, non-federally matched.

   b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to the non-matched programs, services are available through six county hospitals, one state health service center, two state facilities for the mentally retarded, and three state psychiatric facilities.

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

This year AFDC benefits were raised by $1.65 per family member as a result of new social services appropriation legislation.

South Carolina does not supplement federal SSI payments. The state did, however, raise the ceiling under its OS program (a special optional supplementation program for persons residing in licensed residential facilities) from $355 to $410 as of July 1 of this year. DSS is also anticipating further increases in this nursing home "cap" now that it has determined that a section 209(b) spenddown program is financially impractical for South Carolina (see Question 1g below).

   b. Are states changing resource criteria?

The State recently considered a switch to a 209(b) eligibility program for aged, blind and disabled persons. Under 209(b) the state would have reinstituted the restrictive resource levels employed as of January, 1972. These resource levels are $750 for an individual and $1,000 for a couple. The state would also have reinstituted a 1-year prohibition against transferring assets with the intent of becoming eligible for Medicaid. It appears that the transfer prohibition was the major attraction of the 209(b) program.

In light of its decision (see Question 1g) not to implement a 209(b) program, the State will remain a non-1634, SSI-linked Medicaid jurisdiction.

For AFDC recipients, any available money from the sale or transfer of property is to be pro-rated into the household budget for 6 months. (See Welfare Regulation 2511.3, attached as South Carolina-1.) If no money is actually available from a sale or transfer, then no

penalty is imposed for the transfer. No changes in AFDC resource levels are contemplated.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

The following children under age 21 who reside in a licensed foster home or licensed child-caring institution are eligible for Medicaid so long as their available income and resource levels do not exceed those for an AFDC family of one: (a) children who receive non-AFDC foster care payments, (b) children benefitting from Title XX maintenance payments, (c) children being supported by public funds, (d) children in public mental institutions who are receiving active treatment and who are otherwise eligible for Medicaid.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are covered and there are no plans to change such coverage.

e. What is status of coverage of AFDC-UF families?

Children deprived of parental support or care by reason of the unemployment of the father are not covered in either the AFDC or Medicaid programs. There is no plan to establish coverage.

f. Are states proposing changes in operation of spenddown?

South Carolina has no spenddown program. Staff indicated that the State is considering establishing a medically needy program.

g. What are states doing with respect to a 209(b) option?

In the fiscal year 1979 appropriations bill, the South Carolina legislature mandated the Department of Social Services to institute the 209(b) program for aged, blind and disabled persons as of January, 1979, unless DSS could prove by October of 1978 that such a switch would be financially impracticable for the state. For months, the Department intensively researched the issue and on October 1, officials within the Department concluded that such a switch would be financially wasteful (the report prepared by DSS is included here as South Carolina-2). This conclusion was reached for a number of reasons.

First, in talking with Medicaid officials in Mississippi, Ohio, and other states, DSS determined that the cost of administering a spenddown program would vastly outweigh potential savings to be achieved through more restrictive income and resource criteria. Officials reached this conclusion because of the fact that the State's match for administrative costs is twice as high as its match for service costs. DSS officials felt that it would be unwise to decrease the amount of Medicaid coverage in favor of heightened administrative costs.

Second, the State is concerned with soaring nursing home costs. Many officials feared the effects that an open-ended spenddown program would have on SNF institutionalization. It was felt that it would be wiser to raise the nursing home "cap" to a full 300 per cent of SSI payment standards.

Third, officials feared the administrative hardships which a spenddown program imposes on caseworkers.

Finally, while the various aging groups in the state have favored an open-ended spenddown program, officials surmised that in a state as poor as South Carolina, the number of persons whose income exceeds a 300 per cent nursing home cap is vastly out-numbered by those persons who would lose Medicaid eligibility were a 209(b) program instituted.

2. Compare use and operation of spenddown provision among states.

South Carolina does not have a spenddown program.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

    a. What limits are being considered on amount of service?

South Carolina imposes no restrictions on outpatient and physician visits for Medicaid recipients at the present

time. The State is, however, contemplating some sort of curb on these visits which might take the form of a flat limitation of 2 visits per month. This restriction is presently applicable to general assistance clients.

The State has developed no prior authorization procedure for persons whose medical condition necessitates more than 2 physician or outpatient visits per month. The State currently imposes an inpatient hospital limit of 40 days per year for the categorically needy and there is no plan to reduce inpatient coverage at the present time. General assistance patients are restricted to 10 days per fiscal year.

South Carolina is extremely concerned about the cost of skilled nursing facility care. As of July 1, 1978, provider participation in Title XVIII became a condition of participation in Title XIX. PSRO review for Title XVIII is now treated as binding for Title XIX purposes as well. No flat limitations on SNF stay are contemplated. Home health visits are limited to 100 per year after exhaustion of Medicare coverage.

Recently the state limited reimbursement for EPSDT-only services (i.e., vision, dental and hearing). Until July, South Carolina had reimbursed providers for all EPSDT-only services whenever the medical necessity of such services was documented. HEW informed the State, however, that unless a child had been formally screened, no reimbursement for EPSDT services could occur even where medical necessity was established. The State feels that this screening requirement will result in a dramatic decrease in coverage of EPSDT services.

b. What changes are anticipated in coverage of optional services?

No changes are expected in coverage of optional services except the imposition of copayments described in 3c. Certainly no expansion of coverage is likely.

c. Are copayments being imposed? If so, at what level and on what services?

The State has for some time imposed a $.50 copayment on prescription drugs. As of April 1, 1978, the following copayment policies were instituted: (a) durable medical equipment: a copay of $.50 to $3.00 is imposed depending

upon the value of the item; (b) podiatry and optometric services: a $1.00 copay for each; (c) adult dental services: $1.00 copay. The State feels that copayments are an effective means for curbing utilization.

d. Is prior authorization being imposed?

South Carolina uses prior authorization for a variety of services. When a recipient requires a drug not listed on the formulary prior authorization is required. The prior authorization procedure requires approximately 24 to 48 hours for clearance. Prior authorization is not available on evenings or weekends.

Prior approval is required before dispensing durable medical equipment, orthotic and prosthetic devices. There is approximately a 1 to 2 day turnaround time on prior approval for these items. Prior approval must be obtained for physical and occupational therapy in skilled nursing facilities. The SNF rate however does include physical therapy treatment as part of the overall rate. Where automobile transportation is provided by a non-relative and reimbursement is sought, prior approval is required.

4. Identify and assess activity with state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

The State has no plans to limit physician fees and it feels that a limitation on fees is an unreasonable cost-containment procedure. Physician fees under Medicaid are reimbursed on the same basis as Medicare. The average reimbursement for an office visit is $10.

b. Are formularies for drugs being restricted?

South Carolina does have a drug formulary but has no plans for further restrictions on the scope of the formulary at the present time. The State is contemplating the idea, however, of devising special drug formularies for nursing home patients and is at the preliminary stage of evaluating unit dosage packaging for this portion of the Medicaid population.

c. Miscellaneous.

Various types of cost-containment procedures are being undertaken. For example, for fiscal year 1979 South Carolina will implement a second opinion program for

Medicaid services by means of PSRO review. A cost-containment committee was established which includes third party payers and the State Insurance Commission. The hospitals have pledged themselves to a 2 per cent per year reduction in costs. One of the possibilities that state officials are looking at now is the establishment of an across-the-board rate-setting commission. Officials assume however that it will be very difficult to convince the legislature to enact this type of commission.

The State is also attempting to recertify many SNF patients as ICF residents and is contemplating a moratorium on Medicaid SNF beds.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

    a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Persons who do not satisfy federal Medicaid categories may be eligible for limited medical assistance in two situations. First, the State administers GDA, which is a special program of general disability assistance providing nominal cash payments and limited medical coverage for people who are totally but temporarily disabled. Until July 1 of this year, GDA recipients were eligible for medical benefits in the same amount, duration and scope as federal categorical recipients. On July 1, however, the program was cut back so that now only the following services are available: (a) 10 days hospitalization per year; (b) physician care only in hospitals; (c) 2 outpatient visits every 30 days. Under the GDA program, Medicaid coverage lasts for 6 months, whereas it used to be renewable up to a total of 18 months. The GDA program covers about 500 persons at any given time.

The second program is known as GA-Ineligible Spouse. Under it, the ineligible spouse of an SSI recipient receives $30 per month from the State. He or she receives State-funded medical assistance as well in the same amount, scope and duration as GDA recipients.

    b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

For intact families, there is no State program of medical assistance. DSS officials contemplate that these families can turn to other sources for medical assistance. County indigency funds are distributed from the State treasury to each county with variations in amount depending on the size of the county. The county department of DSS makes the financial eligibility determinations. According to South Carolina officials, there are no written income and resource guidelines.

The Hill-Burton program offers many indigents free or reduced-free care. A number of public clinics are run by the Department of Health and Environmental Control. These clinics offer the following services: (1) cancer screening, (2) renal dialysis, (3) Crippled Children's Programs, (4) vocational rehabilitation programs, (5) Maternal and Child Programs, (6) programs administered under the Commission of the Blind, and (7) home health services.

Several county hospitals in the State also tap into the county indigency funds for care of low-income persons. Finally, the Duke Foundation, a private non-profit foundation, provides some medical assistance for indigent persons.

The State feels that the worst aspect of today's Medicaid program is that it provides no catastrophic medical insurance coverage for impoverished intact families.

UTAH

1. Analyze potential changes and trends in eligibility criteria for Medic aid

a. Are states changing income criteria?

Income criteria were increased in Utah effective July 1, 1978. The state legislature sets the need level. AFDC benefits are set at 77 per cent of the need level. The maintenance need level for the medically needy is set at 100 per cent of the need level. These standards are usually updated yearly during the budget process. Present need levels are: (1) 229, (2) $316, (3) $401, (4)$486, (5) $596, (6) $697, (7) $742, (8) $787, (9) $832, and (10) $878.

Effective July 1, 1978, Utah also began a $10 optional supplement on SSI payments.

b. Are states changing resource criteria?

Resource criteria were raised in late 1974 or early 1975 from $600 for an individual to $1,500 for an individual, and from $1,200 for a couple or family to $2,250.

Utah presently has a 1-year transfer of property prohibition. This is a rebuttable presumption, and the staff indicated that in those cases which go to hearing, beneficiaries win nearly every one. The transfer of property prohibition was deleted in 1974, it was put back in 1974 as a 5-year transfer prohibition. It was then reduced to 1 year, then further reduced to 6 months, and then re-upped to 1 year. The staff indicated that there was at least some pressure to eliminate it last year.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Utah provides Medicaid for all financially eligible children under 21 based on the maintenance need standard. Families exceeding this amount can spenddown to the maintenance need level.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are included in both the state AFDC and Medicaid program. $15 additional is added to the AFDC need standard. However, no additional amount is added to the medically needy standard in determining eligibility.

e. What is status of coverage of AFDC-UF families?

Utah includes families with unemployed fathers in its AFDC and Medicaid programs. A 100 hour standard for unemployment is applied on application. However, once a family is on aid, eligibility continues for 1 year after exceeding the 100 hour limit so long as income is less than the grant level. If at the end of one year income is still less than $50 over the grant level, then the family receives an additional 6 months of eligibility. Medicaid for these families is provided with state-only funds as described in Question 5a.

f. Are states proposing changes in operation of spenddown?

No changes are expected in the spenddown system. One uncertain feature is the prior month budgeting that is used for medical care calculations. Increases in income are figured into spenddown calculations with a 2-month lag. These income changes are reported monthly on Form 632 (included as Utah-1) which must be filed by the eighth of the month. Decreases in income are adjusted for the current month. The staff indicated that this feature of the program was designed to avoid the infirmities of the California prior month budgeting system. (Applicable regulations are included as Utah-2.)

The Utah spenddown system has also been challenged by the HEW Regional Office because, as described in Question 2d, it does not utilize incurred medical expenses.

g. What are states doing with regard to 209(b) option?

The staff indicated that Utah became a 209(b) state effective January 1, 1974, because SSI income standards were viewed as too high. As a result, too many individuals would have been added to the rolls. Since that time, state income standards have been raised to 100 per cent of the state need level from 85 per cent. As a result, the maintenance standard is now higher than the comparable SSI level.

Income disregards for the aged, blind and disabled of $20 are applied. If working, the state allows $30 work-related expenses plus mandatory deductions. One of the other main features of the Utah program under 209(b) is an unlimited duration of deeming for spouse to the institutionalized spouse. This is calculated after exempting the maintenance standard plus insurance premiums plus income disregards plus $30 and 1/3 for the non-institutionalized spouse. This deeming approach is presently being challenged in court.

2. Compare use and operation of spenddown provision among states.

   a. Are states changing income lines or operation of spenddown?

As indicated, the state has liberalized income lines for the spenddown program.

   b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

The medically needy spenddown and 209(b) spenddown are operated the same way.

   c. What groups use the spenddown provision? How is public informed about spenddown provision?

The staff indicated that limited demographic characteristics were available on the groups using the spenddown provision as distinguished from the medically needy population in general. Of the 3,232 spenddown eligibles as of September, 1978, 3,071 were aged (2,138) or disabled (933). 2,877 were in nursing homes. Of these, 1,984 were aged and 846 were disabled. (See Utah-3.)

Utah does some outreach on its spenddown program. The Assistance Payments Administration prepares pamphlets which are distributed through community groups and institutional providers. Many institutional providers have their own social workers. Most spenddown recipients learn about the availability of the program through institutional providers, especially nursing homes.

   d. How is spenddown administered?

Utah has a rather unique administration of its spenddown program. The Regional Office has repeatedly taken

exception to this approach but has never taken it to a compliance hearing.

An individual applies for eligibility through a district office of the Assistance Payments Administration. Spenddown liability is calculated on a Form 417A (included as Utah-4). Eligibility is based on monthly accounting periods for the medically needy as well as for 209(b) applicants. Monthly accounting periods were instituted approximately 2 years ago.

In the outpatient setting, excess income is paid to the State Department of Social Services, Assistance Payments Administration. A Medicaid card is then issued through the state. Thus, the spenddown liability is treated as a premium which must be paid before eligibility can be established. A form to guarantee payment to providers can then be generated through the district office. The staff indicated that this guarantees provider participation in the program. Incurred medical expenses become irrelevant since once the spenddown liability is met, by payment of the "premium" to the department, all medical expenses incurred are paid for by the state.

In the nursing home context, the institution collects the excess income after receiving information from the state regarding the individual's liability. This information is transmitted on the nursing home payroll.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

    a. What limits are being considered on amount of service?

Effective February 1, 1979, at the earliest, Medicaid transportation services will be reduced. Presently, emergency and all necessary non-emergency transportation is covered including taxi services. The staff noted problems with determining the medical necessity of taxi services. Presently, only a post-payment review is applicable.

After September 1, the need for medical transportation will be determined on intake by the Assistance Payments Administration. There will be a special imprint on the Medicaid card. All beneficiaries will still have access to emergency transportation. When non-emergency transportation is approved, a chit will be sent out with the Medicaid card for non-recurring needs. If an individual is unable to use public transportation, the

staff indicated that Serve-A-Car or limited taxi service or private vehicles might be authorized for reimbursement.

Dental services are provided pursuant to a contract with Delta Dental. A capitation fee is paid based on utilization figures plus an 11 per cent administrative fee with cost-settling at the end of contract periods. Different capitation rates are established for different categories of individuals.

Utah also contracts with the Family Health Plan, a certified HMO, to serve approximately 8,000 enrollees. Enrollees enroll for a period 6 months. No door-to-door solicitation occurs for Medicaid beneficiaries except if an individual is contacted as part of an outreach effort for private patients.

b. What changes are anticipated in coverage of optional services?

Intermediate care facilities for the mentally retarded were included effective March 18, 1977. Prior to this time, such services had to be provided either in state facilities or nursing homes.

The staff indicated there is also some pressure to expand coverage of small group homes as intermediate care facilities for either the mentally retarded or developmentally disabled.

The staff also indicated that some expansion of home health services is expected. Presently, there are 9 certified agencies in the state. Services are reimbursed on a prior authorization basis to Medicare certified agencies. Charges are reimbursed up to the Medicare limit.

Three rural health clinics have been set up for Medicare. No Medicaid clinics presently exist since state law does not recognize rural health clinic services as a category of Medicaid service. Changes have been proposed for the January session of the legislature.

c. Are copayments being imposed? If so, at what level and on what services?

Copayments are not presently being imposed under the program. This is due to opposition by the state agency.

Cost-sharing of $1.00 to $19.00 was being imposed on medically needy families as an enrollment premium. The staff indicated that these charges were never really implemented and are not presently in use because they were found to be too costly.

d. Is prior authorization being imposed?

Prior authorization is being imposed on a variety of services. Prior authorization forms are sent to the Salt Lake City office. They are reviewed there by physician consultants, who are part-time staff, or by pharmacy consultants. Turnaround time equals approximately 1 week. Providers can appeal to staff medical consultants. Beneficiaries are not directly notified and must learn about the denial and their appeal rights through the provider.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physician fees are reimbursed at 80 per cent of usual and customary charges up to the 75th percentile of Medicare reimbursement and up to the Medicaid median. The staff indicated that this has resulted in some problems and provider participation, especially in Weber County (which includes the City of Ogden). The staff estimated that the program is paying 67 per cent of usual and customary charges in that county. They have been unable to get an increase through the legislature in recent years. Fees are at the same level as prior to 1970. (A copy of the Physician Manual is included as Utah-5.)

b. Are formularies for drugs being restricted?

Utah uses an open formulary divided into therapeutic classes and includes over-the-counter drugs. Legend drugs are reimbursed on the basis of MAC and EAC. A variable dispensing fee is used. This is minimal for contraceptives and insulin. Over-the-counter drugs are reimbursed on a 50 per cent add-on to cost.

Some minimum dosages are used. Some drugs such as amphetamines are excluded from the program except for hyperkinetic children. In such cases, prior authorization is required.

c. Miscellaneous.

The main cost control system applicable to inpatient services is the statewide PSRO. A utilization coordinator compares admission data with PSRO criteria. The PSRO maintains a statewide data system. The PSRO also does ambulatory care review. The staff felt that the PSRO is beneficial but it needs "a greater thrust towards direct economics" and less of an "educational" function.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Utah provides services to non-Medicaid eligibles through the "county indigent program." Counties had a pre-existing obligation under state law. They can meet this obligation by assigning proceeds of a one-quarter mill levy to the state. This program was pushed by the major counties in Utah and became operational in July of 1977. Only 8 or 9 counties participate, but this is the majority of the state population.

There are restrictions on eligibility and services. The Assistance Payments Administration determines eligibility and medical reimbursement. During 1977, the budget of the program was $1,300,000. Of this amount, $800,000 was county funds. The staff indicated that there is no real data on how much money the other counties are paying. The same payment mechanism is presently used as for Medicaid. (A copy of the County Indigent Medical Program Manual is included as Utah-6.)

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to the county indigent program, the main source of medical care for indigents is the University of Utah Hospital. No data was available on the amount of non-reimbursed services available.

VIRGINIA

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Effective July 1, 1978, the eligibility levels for the medically needy program were increased. These medically needy levels are set by the state agency at 133-1/3 per cent of the AFDC levels. Since the state legislature had increased the AFDC levels effective July 1, 1978, an increase in the medically needy levels was possible. (These medically needy eligibility income levels are set forth in the informational pamphlet included as Virginia-1.)

   b. Are states changing resource criteria?

The only major change affecting resource criteria implemented or proposed was the change on July 1, 1976, when Virginia became a 209(b) state. This change is discussed in Question 1g.

   c. Is "Ribicoff children" option being used for some specific groups of children or all children?

The "Ribicoff children" option is being used for some groups of children. These groups are: (1) children for whom public agencies are assuming full or partial responsibility and who are in foster homes, private child-caring institutions, or intermediate care facilities, and (2) children in subsidized adoptions.

   d. Are unborn children covered? Are there plans to change such coverage?

Unborn children were included for a period of time in the Virginia AFDC program and in the Medicaid program. Apparently, after the decision of the United States Supreme Court in Burns v. Alcala (1975) 420 U.S. 575, coverage was deleted. Thus, a mother pregnant with her first child cannot establish eligibility. There is no Medicaid coverage available until her delivery. Such individuals must rely on public clinics for pre-natal care.

Part of the policy reason for this deletion of coverage, expressed by the staff, was that young women pregnant with their first child were using this program as a means to get coverage for their abortions. Since there is strong opposition in this state to coverage of abortions, Medicaid coverage was deleted for the unborn. There is no present intention to re-establish this coverage.

e. What is status of coverage of AFDC-UF families?

There is no AFDC-UF program in Virginia, and no coverage under the Medicaid program.

f. Are states proposing changes in operation of spenddown?

No changes are being proposed with regard to operation of the spenddown program.

g. What are states doing with regard to 209(b) option?

Virginia became a 209(b) state effective July 1, 1976. Prior to this time they were not a 1634 state. Three reasons were described as the basis for the policy change.

First, it was felt there were a substantial number of cases in which property was transferred to establish or maintain Medicaid eligibility. As a result, the state wished to establish a prohibition on property transfers without justifiable reasons. Justifiable reasons do not exist where equivalent value is not received for the property. Eligibility in such cases is prohibited for 12 months following the transfer.

In the situation in which an eligible individual enters a nursing home, the state continues to exempt the home as a resource if it is being occupied by a dependent child or dependent spouse even after the sixth month of institutionalization. As a result, the institutionalized spouse need not transfer his/her property interest in the home in order to maintain Medicaid eligibility.

The second factor discussed was the exemption under SSI of all property contiguous to the home. Under the SSI program, a home occupied by an eligible individual of any value is exempt as a resource. This exemption also includes property contiguous to the home. The state

administration was concerned with situations in which up to 200 acres of farm land may be contiguous to the residence. Virginia now limits this exemption to the house and lot (including a garden, well, and up to about 3 acres in a rural area).

The third reason expressed by staff for electing the 209(b) option was that the state was unwilling to provide eligibility for conditionally eligible or presumptively eligible individuals. It was felt that these requirements would be administratively cumbersome and financially unworkable as applied to the medically needy categories.

Other than these three more restrictive criteria, the state applies the same income disregards, and the same linking definitions as the SSI program.

2. Compare use and operation of spenddown provision among states.

    a. Are states changing income lines or operation of spenddown?

As described earlier, the income lines for the spenddown program were increased effective January, 1978.

    b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

The 209(b) spenddown program and the medically needy program are operated the same. Both use a 6-month accounting period for nursing home patients. This accounting period is shortened as a practical matter to one month. Each month, the nursing home resident receives a notice of the amount of money that he/she will have to contribute to the cost of nursing care.

    c. What groups use the spenddown provision? How is public informed about spenddown provision?

The State computer system can document how many spenddown cases are open at any given time. Statistics are not kept routinely, however, as to the amount of medical assistance paid for this group. No information was available on this point during the field visit.

The public is generally informed about the spenddown provision in one of two ways. Many people find out when they apply for Medicaid and are informed that their income is too high. The State has prepared a flier explaining the spenddown program (included as Virginia-2). This program is also explained in the general informational pamphlet (Virginia-1). Other individuals are informed of the medically needy program by institutional providers such as a hospital or nursing home when an individual is admitted for services.

d. How is spenddown administered?

Virginia uses a 6-month accounting period and determines eligibility based on incurred medical expenses. The state maintains a computerized enrollment file which can be updated directly by workers in welfare offices in large metropolitan areas, or by fiscal intermediary CRT operators after telephone contact by other welfare offices. The state maintains three eligibility codes: (1) ongoing, (2) retroactive, and (3) spenddown.

Form W-2408 (included as Virginia-3), is used to calculate spenddown eligibility. Up until late 1975 or early 1976, an applicant who exceeded his/her spenddown liability by up to $50.00 on a particular day was not reimbursed for that excess spenddown liability. This was changed after the policy was identified by HEW in a field visit. Now, the state looks at medical expenses in the chronological order in which they are incurred.

Eligibility often begins with the bill in which the individual exceeds the spenddown liability. As a result, the state occasionally reimburses a medical provider for a bill, a portion of which may have been used to satisfy the spenddown liability.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

The present limits in the Virginia Medicaid program were largely imposed effective January 15, 1975. This was the major crisis date in the Virginia program. The staff has unsuccessfully attempted to get these cutbacks restored by the legislature on several occasions in succeeding years.

Inpatient hospital services are limited to 14 days, or 21 days for certain procedures. This limit does not apply to Medicare-Medicaid beneficiaries for whom the state pays deductibles and other costs. This coverage may be supplemented by the state and local hospitalization program discussed in Question 5.

b. What changes are anticipated in coverage of optional services?

The state is considering an additional class of "Ribicoff children." This would be all children under 21 in psychiatric facilities. Presently, there is no real coverage available for children in need of long-term psychiatric care. There is also a paucity of facilities available in the state due to a lack of funding.

The state is also proposing a limited adult dental program which would cover extractions to lessen pain or infection. Presently, adult dental care is available only through public health clinics for medically indigent individuals.

There is also support within the department for ending copayments on prescription drugs. This support is based on several factors. First, the advent of MAC has lessened costs for major drugs. Second, copayments impose an unfair burden on low-income individuals.

c. Are copayments being imposed? If so, at what level and on what services?

Copayments are presently being imposed only on prescription drugs. A $.50 copayment is collected by the pharmacy from the Medicaid beneficiary. Because the state uses the Medicare reimbursement formula for inpatient hospital services, copayments are not imposed on hospital inpatients. Presently, copayments for prescription drugs are also not imposed on SNF or ICF residents. HEW has taken exception to this policy as conflicting with comparability requirements. The state has not decided how seriously they will fight this opposition. The Regional Office has indicated that copayments could be avoided on nursing home residents by including prescription drugs within the nursing home reimbursement rate.

d. Is prior authorization being imposed?

Prior authorization is being imposed on a variety of services. Routine vision services, non-emergency transportation, durable medical equipment (including ostomy supplies, dialysis supplies, and oxygen) are subject to prior authorization. EPSDT dental services are also subject to prior authorization.

Dental examinations with radiography, emergency treatment with required radiography, dental prophylaxis (limited to once every 6 months), flouride treatments (limited to once every 6 months), amalgam restorations, silicate restorations, acrylic or plastic restorations, emergency treatment of dental pain, and anesthesia may be provided without prior authorization of the state agency. All other services are subject to prior authorization. In such cases, a dental preauthorization request (included as Virginia-4) is completed by the dentist. This form lists the procedures requested and is usually supported by X-rays and a treatment plan.

The form is initially screened based on the patient's history to insure, for example, that the same tooth is not going to be pulled twice. The request is then reviewed by a dental staff person for adjudication. For some endodontic services, an outside consultant is used. The provider is notified of the decision and the dentist may then complain to the dental director. The staff indicated that this hardly ever occurs.

Psychiatric care is ordinarily limited to 50 hours in a patient's lifetime. Additional care is available beyond that with prior authorization. Prior authorization is handled by a psychiatric review board which can grant additional services for specified periods. Any appeal from the psychiatric review board determination would be handled as a recipient appeal, but only one such appeal has ever been filed.

Certain physician procedures also require prior authorization. These include such procedures as bypass surgery and cosmetic surgery.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

   a. Are physician fees being limited?

Physician reimbursement is based on the lower of actual charges or what Medicare will allow. Such fees must also be less, however, than specified caps for specific

procedures. These procedures are defined using the AMA RVS procedure codes.

The staff noted that while these caps were initially very high, the fees have begun to come up against them. As a result, the staff is thinking about an increase in the cap.

The staff estimated that approximately 70 per cent of the physicians actually practicing medicine in the state are treating Medicaid beneficiaries. They noted difficulties in determining which physicians are actually in practice. They do not base this estimate on minimum numbers of Medicaid beneficiaries seen.

Dental fees are based on the 75th percentile of usual and customary charges. This schedule has not been updated since 1972-1973, however. Some support has been expressed for raising these fees.

b. Are formularies for drugs being restricted?

Virginia covers any legend drug except anorexants. Anorexants may be authorized occasionally for hyperkinetic children or for individuals suffering from seizures. Propoxyphenes (like Darvon) were restored to the drug program effective July 1, 1978. The main reason for this restoration was that the advent of MAC had lowered the cost of these drugs significantly. In addition, some physicians, aware of the limitation on Medicaid reimbursement for propxyphenes, had been prescribing codeine products.

The January 15, 1975 cutbacks had significantly limited the availability of over-the-counter medications. Presently, the only non-legend drugs covered are insulin syringes, needles, and family planning supplies.

Virginia does not impose any minimum or maximum quantities on drugs. Physicians are encouraged, however, in provider bulletins to prescribe maintenance drugs in larger quantities. In addition, possible situations of abuse by pharmacies are identified during claims processing for counseling. The state uses the standard reimbursement procedure including a $2.75 dispensing fee for community pharmacies.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Non-Medicaid eligibles can receive services with 100 per cent non-federal funding through two main programs. The state and local hospitalization program provides reimbursement for hospital services for non-Medicaid eligibles, and for individuals who have exhausted their Medicaid coverage. State legislation authorizes localities to opt to have the program with 50 per cent state match. Approximately 109 cities and counties participate; 26 cities and counties have no such coverage. There are state eligibility rules with some local discretion.

The second main program is the general relief program. General relief includes some reimbursement for medical care. Primarily this is for physicians and drug services. General relief eligibility is based on 65 per cent of the state welfare grant levels.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to the above programs, the state depends on Hill-Burton obligations, hospitals writing indigent care off as a bad debt, and care in state facilities as the main sources of care for medically indigent adults.

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Washington last updated income criteria effective July 1, 1978. Medically needy levels, for example, were increased from $219 to $231 for 1 person. Medically needy levels are not quite at 133-1/3 per cent of the AFDC levels. AFDC levels are also updated in July depending on the appropriations available. (AFDC grant levels are set forth in Washington-1.) Medically needy percentages are based on the highest county level for AFDC (King County). (Medically needy levels are set forth in Washington-2.)

   b. Are states changing resource criteria?

Washington exempts a house and car and most personal property. Non-exempt property for the aged, blind and disabled and for the AFDC medically needy is limited to $1,500 for an individual and $2,250 for a couple or family. The AFDC categorically needy property limit is $750 ($200 in cash, $550 in other resources).

Washington has a transfer prohibition disqualifying an AFDC categorically needy applicant or recipient who transfers any resource within two years of applying for aid. The resource transfer for less than fair consideration results in a 2-year disqualification. This transfer prohibition applies to both the AFDC program and to the non-Medicaid state-funded medical-only program. (A copy of this transfer prohibition is included as Washington-3.)

In the situation in which a spouse is institutionalized, Washington continues to exempt the home indefinitely if it is occupied by a dependent spouse and/or dependent child.

   c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Washington covers all "Ribicoff children."

   d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are included in both the Washington AFDC and Medicaid plans. The staff indicated that eligibility

may actually be provided before medical verification of pregnancy, although most offices do require medical verification.

e. What is status of coverage of AFDC-UF families?

Washington includes families with unemployed fathers in its AFDC program. The federal definition of unemployment is used. These individuals are described as the "E" category.

f. Are states proposing changes in operation of spenddown?

Washington is considering significant changes in its spenddown program for adoption by mid-spring of 1979.

g. What are states doing with regard to 209(b) option?

Washington is a 1634 state and has never seriously considered the 209(b) option.

2. Compare use and operation of spenddown provision among states.

a. Are states changing income lines or operation of spenddown?

As indicated previously, Washington increased its income lines for operation of the spenddown program effective July 1, 1978.

b. Is the spenddown provision under 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

Washington is not a 209(b) state.

c. What groups use the spenddown provision? How is public informed about spenddown provision?

The staff was not able to break down the demographic characteristics of the groups using the spenddown program as distinct from the medically needy program generally. As in other states, the medically needy program is overwhelmingly aged and disabled individuals.

As in most other states, individuals learn about the spenddown provision primarily through institutional

providers. The state conducts no outreach to encourage participation. (A copy of the State's descriptive flier is included as Washington-4.) Information is provided at the time of eligibility determination through the award letter issued by the local office.

d. How is spenddown administered?

The staff indicated that the Regional Office has raised some compliance issues regarding Washington administration of the spenddown program. As a result, the staff consistently referred to their program as "participation" rather than spenddown. A 6-month accounting period is used for recipients at home, and a 12-month period for recipients in institutions.

When a recipient has incurred sufficient medical bills, the staff indicated that liability for payment by the recipient is assigned to the vendor with the largest medical bill, rather than in a chronological tracking of medical expenses. The staff indicated that this will probably be changed effective January 1, 1979. (A copy of the eligibility standards is included as Washington-5.)

3. Identify and analyze current and potential benefit restrictions under Medicaid.

a. What limits are being considered on amount of service?

The staff indicated that limits are being seriously considered under the Washington Medicaid program. A serious deficit was incurred this biannium (2-year budget period) of $20 million. The staff indicated that without cuts, a $100 million deficit will be incurred next budget period.

Possible cuts include putting general assistance recipients (state-funded, non-Medicaid) on a very limited scope of services described as acute and emergent (see Question 5a), freezing provider fees, improving utilization review, eliminating durable medical equipment, expediting discharge from hospitals to long-term care, increasing state-only deductibles to $200 (see Question 5a), prospective rate- setting, improving third party liability collection, improving fraud and abuse detection, eliminating the state dental program, eliminating the medical only program, eliminating the general assistance program for medical care, eliminating the medically needy program, limiting the medically

needy to acute and emergent scope of services, and restricting the prescription drug program. None of these cutbacks are at a serious discussion stage, but the staff indicated that some steps will have to be taken.

One additional limit applies to eyeglasses. The material aspects of the eyeglasses must come from Bausch & Lomb pursuant to a contract with the state. The recipient cannot supplement the state schedule of fees for a more expensive frame or lens. If the recipient desires a frame that is not available under the state plan or a special tinting which is not available, the recipient must bear the entire cost.

The staff indicated that except for a brief period in 1967 when no trouble existed in the Medicaid program, costs have been a continuing problem.

b. What changes are anticipated in coverage of optional services?

Most of the limits discussed in Question 3a also relate to proposed scope of optional services. Washington already covers most optional services, and no major changes are expected. Coverage of services is described in the Physician Manual (included as Washington-9).

Rural health clinics are generally already providers in the Washington Medicaid program as general clinic services. Thirteen rural health clinics have been certified. The staff indicated that the Washington physician extender law has been interpreted to allow nurse practitioners only to practice when doctors supervise.

Beyond the requirements that a physician request home health services and prior authorization, no real limits exist on provision of home health services.

c. Are copayments being imposed? If so, at what level and on what services?

Washington had copayments only on the medically needy. This was found to be a totally "unrealistic" approach. Copayments were originally imposed in response to provider pressure as a justification for raising provider fees. This was a relatively brief fling since the staff indicated that it was felt that copayments would actually cost the state money.

d. Is prior authorization being imposed?

Prior authorization is extensively used in the Washington Medicaid program. It is applied to all elective surgery with length of stay reviewed by the PSRO. Drugs prescribed outside the formulary or in excess of $25.00 must be prior authorized. Physician visits are limited to 1 per month for non-emergency situations and 2 visits per month for emergency situations. The staff indicated that this is enforced by a pre-payment, post-service review.

Prior authorization is required for dental services except for emergency care. Even in the emergency care situation, all services must be provided within 14 days. Orthdontia is not covered under the state program. Other services subject to prior authorization include home health services (after $350 in services) and durable medical euipment above specified values. Prior approval is no longer required for physical therapy and related services, eyeglasses, and non-emergency transportation.

Providers apply for prior authorization on a claim form submitted to the local medical consultant. This medical consultant is located in the local community service office. Some of these consultants are hired on a contract basis, others are on staff. The staff indicated that a 3-day maximum turnaround is applicable to prior authorization requests. The recipient is notified of a request denial and is informed of fair hearing rights. (Copies of the request forms are included as Washington-6, -7, and -8.)

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physician fees are based on the California 1969 RVS supplemented with the AMA CPT-3 (Current Procedural Terminology). The staff indicated that the state is now moving to the CPT-4 and California RVS from 1974. The conversion code is now at $7.14 per unit. The staff indicated that there have been some modifications of unit values. Physician participation is still a problem in the program despite a 5.5 per cent increase in fees effective July 1, 1978 to all providers. Only 7,400 out 18,000 providers in the state actually participate.

b. Are formularies for drugs being restricted?

Washington uses the MAC and AAC (Actual Acquisition Cost). The staff indicated the state is using a tape-to-tape exchange for updating redbook prices. Two different dispensing fees are used depending on whether the pharmacy is an institutional or non-institutional provider. In addition, there is a third group for state institutional providers.

Effective July 1, 1978, the regular dispensing fee for pharmacies was $2.48. For small pharmacies filling 35,000 or less prescriptions per year, a special add-on of $.12 is provided. This is described in the Schedule of Maximum Allowances for Pharmacists (included as Washington-10). Washington uses an open formulary with prior authorization required for most non-formulary and for over-the-counter drugs. (A copy of the drug request form is included as Washington-11.)

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

    a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Washington has 2 major state funded programs. The first is its program of medical care for general assistance recipients. The staff indicated that these are usually individuals who cannot meet the duration of disability requirement for SSI. The Medicaid scope of services is provided except that no out-of-state services are reimbursed. During the past biannium costs for this group amounted to approximately $26.4 million.

The second major program is the medical only program. This is also described as acute and emergent care for individuals 21 to 65. Services are limited to a maximum of 3 months for 1 condition. As a result, most recipients have usually suffered an accident. There is a $200 deductible, and all treatment must be prior authorized. Individuals must expend their resources except a house and car. Medically needy income standards are used, but the state also considers future income possibilities. State funding of this program amounted to $27.9 million during the past biannium.

    b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

In addition to these 2 programs, the state funds medical services for prisoners in city/county jails as a last resource.

WISCONSIN

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Effective July 1, 1978, Wisconsin increased its SSI benefit level by passing on the federal cost-of-living increase. In addition, food stamps were cashed out. No cost-of-living increase was made in the state supplement. Benefit levels are set by the legislature after recommendation by the Department to the Joint Committee on Finance.

Medically needy levels are set at 100% of the AFDC standard and are updated every two years on the odd year. Present maintenance levels for the medically needy are: (1) 283.33, (2) 391.67, (3) 441.67, (4) 525.00. There is no cap on family size.

AFDC levels are set at 88% of the need standard. Some local jurisdictions make up this 12% deficit. This local supplementation is disregarded in Medicaid calculations. (A copy of the Medicaid application is included as Wisconsin-1.)

   b. Are states changing resource criteria?

Medically needy resource levels are the same as AFDC for families over two people. SSI standards are used for one and two person families. A family may keep $1,500 in resources for a single eligible person, $2,250 for a couple, and $300 for each additional person. The first car is exempt, as well as a second car necessary for health or employment. In addition, a home and most personal furnishings are exempt.

Wisconsin presently has no transfer of property provision. This is viewed as a sore point in the field and the legislature. A provision did exist which prohibited divestment in the aged, blind and disabled categories. A 2-year disqualification period existed. The Wisconsin Supreme Court invalidated this divestment provision.

Wisconsin has an unusual approach to the situation in which a spouse is institutionalized. If there is no

dependent spouse or child living in the home, the home is exempt for the first six months and may be exempted for an additional six months. Beyond one year, it must be put up for sale, but during the period that it is up for sale, there is continuing eligibility. If the house is occupied by a dependent spouse or dependent child, the house is an exempt resource and the family is treated as an AFDC-linked family including the institutionalized spouse.

c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Wisconsin covers all Ribicoff children in its Medicaid program. This is especially important since 18 to 21 year olds are not covered in the AFDC program. They were eliminated from coverage in 1969. There is a state-financed program for 18 year olds in high school which was enacted this past session. Such individuals will also receive Medicaid benefits.

d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are included in both the Wisconsin AFDC plan and Medicaid plan, but there was a recent liberalization effective July 1, 1978. Now, once pregnancy is medically verified, assistance is granted. A mother pregnant with her first child is treated as a 1-person family budget unit and receives an additional $15 to meet the needs of the unborn child.

e. What is status of coverage of AFDC-UF families?

Wisconsin provides AFDC-UF to the limits of the federal program. It is considering a state-financed program for fathers who work more than 100 hours but who have income less than the AFDC standard. They are presently applying for a waiver for this group but will probably go ahead with the project even if a waiver is not granted.

f. Are states proposing changes in operation of spenddown?

No major changes are planned in operation of the Wisconsin spenddown program.

g. What are states doing with regard to 209(b) option?

Wisconsin is a 1634 state and does not plan to choose the 209(b) option.

2. Compare use and operation of spenddown provision among states.

   a. Are states changing income lines or operation of spenddown?

Wisconsin last increased its income standards for the medically needy program on July 1, 1977. These standards would come up for review again effective July 1, 1979. There is no present intention to increase the medically needy standard above 100 per cent of the AFDC standard.

   b. Is the spenddown provision under the 209(b) option operated the same as the medically needy program in terms of accounting period, etc.?

Wisconsin is not a 209(b) state.

   c. What groups use the spenddown provision? How is public informed about spenddown provision?

Wisconsin has little data on the demographic characteristics of its medically needy population. Although this population is overwhelmingly aged and disabled, there is no data on the percentage of medically needy recipients who attain eligibility by spending down.

Medically needy applicants are generally informed of the program by institutional providers. Individuals who apply for AFDC also apply for medical assistance and food stamps in the same application. As a result, an individual who is determined to be financially ineligible for AFDC but who has substantial medical expenses will be advised of the availability of the medical assistance program. Individuals who apply for SSI and are found financially ineligible are supposed to be referred by the Social Security Administration to the county. The adequacy of that referral system was questioned by the staff. (A copy of the state informational brochure is included as Wisconsin-2.)

   d. How is spenddown administered?

Wisconsin utilizes a 6-month accounting period for its medically needy program. Recipients can use medical

expenses incurred in the 3 months prior to the month of application under the retroactive coverage provision. Individuals under the medically needy program are certified for a period of 6 months. If income fluctuates during this period, that is reflected in the next accounting period.

When an individual has incurred medical expenses over their liability, the state attempts to assist the applicant in receiving compensation for these medical expenses. This is accomplished by attempting to insure that the provider bills for the service and passes on reimbursement to the beneficiary.

One problem arises when the level of Medicaid reimbursement is less than the amount of the charge. If the state reimburses for a covered service, the state policy is that only the amount of the state reimbursement need be refunded to the beneficiary. Thus, in a nursing home that has higher private pay rates than Medicaid rates, an individual who incurs expenses for the first month of stay may have reimbursed the nursing home for more than the Title XIX rate. In this situation, the Medicaid reimbursement is not reimbursement in full to the provider. The staff indicated that it was inappropriate to penalize this provider who took on the patient as a private pay patient.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

    a. What limits are being considered on amount of service?

Wisconsin has a extremely broad scope of services. There are no significant limitations on this scope. The staff indicated there was some reevaluation of the scope of coverage as a cost-containment measure. The staff expressed concern about being left holding the bag for services where federal reimbursement might no longer be available. One of the policy questions that needs to be addressed is whether coverage under the state's Medicaid program should be so much broader than most private insurance coverage.

The staff mentioned the problems in setting up standards for reimbursement of therapy services. Wisconsin is in the process of setting up a number of procedures for reviews. The staff noted that psychotherapy is still a problem, but significant progress has been made toward standard setting in this area as well.

The state applies more restrictive criteria for abortions than the Hyde Amendment. No cosmetic surgery is covered. Transsexual surgery is not covered, but plastic surgery for burn victims is included. The state does cover heart transplants and bypass surgery.

b. What changes are anticipated in coverage of optional services?

The Wisconsin Medicaid Agency is being pressured by other agencies within state government to include additional optional services that are presently being reimbursed out of the social services budget. In this way the state can take advantage of the federal matching available under the Medicaid program.

Among the services that are being considered are personal care services and adult day care services. The staff noted the problem of a doctor prescribing therapy within an adult day-care service in order to make the service federally reimbursable.

Since Wisconsin already provides coverage for newly all optional services, no expansion of operational services is expected in the future.

c. Are copayments being imposed? If so, at what level and on what services?

Copayments are not presently being imposed in the Wisconsin Medicaid program. A draft report in the Governor's office recommends it as a cost-control measure. The staff indicated a desire to seek copayment on therapy services but noted at least one problem. With psychotherapy, there could not be a copayment on psychiatrist (physician) services. A copayment on psychologists would simply encourage patients to utilize psychiatric services which are more expensive to the State. Such a copayment would therefore not be cost-effective.

d. Is prior authorization being imposed?

Prior authorization is being imposed on a number of services. (These services are described in Wisconsin-3.) Prior authorization is administered out of the central office. A provider submits a form to the state medical consultant. (Copies of these forms are included as

Wisconsin-4 through -9.) Generally, within 5 to 7 days (orthodontic cases often take longer), the provider is notified. Both the provider and beneficiary are notified if the request has been denied or approved only in part. This form advises the beneficiary of his/her right to utilize the fair hearing process. (A copy of this form is included as Wisconsin-10.)

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

   a. Are physician fees being limited?

Physician fees were last updated on July 1, 1977. The department is presently in the process of updating these fees again. Before 1977, the last update was in 1974. Wisconsin utilizes the 1964 California RVS with some modifications based on the Milwaukee RVS and some independent descriptions of procedures. The staff indicated that the department is presently considering a statewide fee schedule.

   b. Are formularies for drugs being restricted?

Wisconsin does not restrict drugs to a formulary. Nearly all legend or non-legend medications prescribed by a physician will be reimbursed. The state will not reimburse for such over-the-counter items as hand creams, however.

Drug pricing is based on a Wisconsin drug price file. These drug prices are obtained from a number of sources. Three large wholesalers give the department prices each month. Added to that are prices from 9 manufacturers where a pharmacist can buy direct. Those items, subject to MAC pricing, are then included. In addition, Wisconsin utilizes its own drug formulary for about 30 drugs which under state law can have generic substitution.

The HEW Regional Office has taken exception to one portion of this procedure. Some drugs appear on the MAC price list but not on the state formulary and therefore are not subject under state law to generic substitution. The staff indicated that some change will have to be made in state law.

Once a wholesale price is established from the Wisconsin drug price file, a dispensing fee is added. This fee is presently $2.65 and was increased from $2.40 effective

July 1, 1978. Prior to July 1, 1977, Wisconsin used a variable fee depending on the services provided by the pharmacy.

c. Miscellaneous.

Hospital costs are controlled through a statewide rate review mechanism. This mechanism applies to all reimbursement systems except Medicare. A physician must prescribe home health services. Once prescribed, such services must be rendered by a certified Title XVIII home health agency. These are usually public agencies but include some private agencies.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Wisconsin has several programs for services to non-Medicaid eligibles. The relief to needy indian persons program aids individuals who are otherwise ineligible for Medicaid and live on tax-free lands. These individuals get the same benefits including medical assistance as the AFDC recipients. The state also provides Medicaid with only state funding for those children in foster care under the custody of the state with excess resources or income.

During the period of October, 1977 through July, 1978 approximately $2,150,000 was expended on medical assistance with state-only funds. This was broken down into the following categories: (1) Chronic Renal Dialysis--$507; (2) AFDC-F--$1,289,415; (3) AFDC-I--$207,347; and, (4) Aid to Needy Indians --$642,262.

b. What are the sources of care for medically indigent adults? How many receive services? At what cost?

General assistance is a local responsibility in Wisconsin provided by municipalities, townships, and some counties. There is little pressure for a statewide program. Most localities have some GA medical assistance program with 100 per cent local monies. Generally, there is prior authorization on all services, but emergency services. Rates are negotiated

prospectively with providers who generally accept less than normal fees.

Indigents also receive free services at Milwaukee County Hospital and at University Hospital in Madison. There is little pressure for the creation of a medically indigent adult program. There is some push for inclusion in a 100 per cent state program of individuals in sheltered workshops who become ineligible for SSI after they exceed SGA guidelines.

WYOMING

1. Analyze potential changes and trends in eligibility criteria for Medicaid.

   a. Are states changing income criteria?

Wyoming does not provide optional supplements for SSI recipients. As a result, income criteria were last increased effective July 1, 1978, by the amount of the federal SSI increase.

   b. Are states changing resource criteria?

Wyoming applies no transfer of asset prohibition to SSI-linked individuals. A 2-year transfer of asset prohibition is applicable to AFDC recipients.

   c. Is "Ribicoff children" option being used for some specific groups of children or all children?

Wyoming does not provide Medicaid for any "Ribicoff children."

   d. Are unborn children covered? Are there plans to change such coverage?

Unborn children are included in the Wyoming Medicaid plan upon medical verification of pregnancy, but no sooner than the beginning of the second trimester.

   e. What is status of coverage of AFDC-UF families?

Wyoming does not include families deprived of parental support or care by reason of the unemployment of the father in the state Medicaid program.

   f. Are states proposing changes in operation of spenddown?

The only spenddown program in the Wyoming Medicaid program is the 300 per cent cap spenddown for nursing home residents. Eligibility is processed through the county office, with SSI resource levels applied.

   g. What are states doing with regard to 209(b) option?

Wyoming decided against becoming a 209(b) state because of the additional administrative costs applicable in 209(b) states. Instead, Wyoming is a 1634 state.

2. Compare use and operation of spenddown provision among states.

There is no spenddown in the Wyoming Medicaid program.

3. Identify and analyze current and potential benefit restrictions under Medicaid.

   a. What limits are being considered on amount of service?

The staff indicated that no new limits on scope of services are expected in the near future. The Wyoming Medicaid program is in a fairly stable posture. One of the limits that did exist was on inpatient services. Previously, there was a 14-day absolute cap. Now, this limit is no longer applied, and instead, the statewide PSRO is used. The staff indicated that the PSRO is excellent, although cost-ineffective.

   b. What changes are anticipated in coverage of optional services?

The staff indicated that no expansion of services or reduction is expected in the Wyoming Medicaid program. Some additional expansion of services is taking place under the state-only program. These are discussed in Question 5a.

The staff indicated that the state is considering broadening criteria for home health services. Presently, home health services are limited to home-bound individuals. Beneficiaries must be over 18. Services are reimbursed on the same cost basis as Medicare. Presently there are 14 Medicare-certified home health agencies in the state.

Participation in the rural health clinic program requires a change in state law to add rural health clinics as a covered service. Presently, there are no certified clinics in the state.

The staff indicated that the state had considered establishing an adult dental program. However, they had wanted a very limited program and realized this would be inconsistent with federal requirements.

c. Are copayments being imposed. If so, at what level and on what services?

No copayments are imposed under the Wyoming Medicaid program and no copayments are presently proposed.

d. Is prior authorization being imposed?

Prior authorization is imposed on out-of-state medical care, medical transportation, and cosmetic procedures. Cosmetic procedures can be prior authorized if they are medically necessary, as in the case of facial scaring from a burn.

A physician seeking prior authorization would make a request to the state central office staff for approval. The staff indicated that there is almost immediate approval or a denial. Occasionally, medical consultants are called in complex cases.

4. Identify and assess activity within state to restrict payment for hospital, physician, or other services.

a. Are physician fees being limited?

Physicians are reimbursed based on the 1964 California RVS. On other procedures, the state uses the same coding as the fiscal intermediary for Medicare. The staff indicated that the state is paying about 60 per cent of bill charges. One problem that was noted was that while reimbursement is at the same levels as Medicare, only about 5 per cent of the Medicare-non-Medicaid claims are assigned. As a result, profiles are very low. The staff indicated that almost all doctors in the state participate to the extent of at least 1 claim per year. Active participation, however, is about 70 per cent.

b. Are formularies for drugs being restricted?

Wyoming does not have a Medicaid drug program. A state-only drug program is described in the answer to Question 5a.

5. Assess and document extent of coverage of poor who are not eligible for Medicaid.

a. To what extent can non-Medicaid eligibles receive services with 100 per cent state funding?

Effective July 1, 1978, Wyoming implemented a new state-only program for nursing home residents over the 300 per cent SSI cap. The state was unwilling to establish a medically needy program because of a concern over increased costs. The staff indicated that the state felt that although such a program was funded only with state funds, it would be more managable than a federally-matched program.

The state also has a "Minimum Medical Program" administered through the state welfare department. Although there are presently some county funds under a mill levy, state law provides for a phasing out of this county contribution by 1980. Eligibility for the Minimum Medical Program is the same as under Medicaid except for the requirement of categorical linking. The Minimum Medical Program covers the services available under Medicaid and some uncovered services.

All individuals who are eligible for Medicaid as well as other persons receive prescription drug coverage under the Minimum Medical Program. The staff indicated that the state was going to include prescription drugs in the Title XIX plan until the establishment of MAC and EAC. The state objected to the generic drug overtones of the MAC program. The staff indicated that the state felt that it would further hurt physician participation in the Medicaid program. The state-only program uses a wide open formulary with some coverage of over-the-counter drugs. Reimbursement is based on an agreement with the Wyoming Pharmaceutical Association. This reimbursement equals the Red Book price plus $2.75 as a dispensing fee.

Under the Minimum Medical Program, county welfare directors make determinations of eligibility. The state has mandated coverage of drugs for Title XIX recipients, individuals in licensed shelter care, and children in foster care, and has mandated coverage of other medical needs for all children in foster care. The staff acknowledged that federal matching is available to meet some of the expenses. However, this would require a change in state law and there has been no attempt to seek such a change.

Each county is given an allocation under the Minimum Medical Program based on 2 factors: (1) the number of people in the county, and (2) past expenditures. Money is occasionally transferred from county to county, and it

is not infrequent for funds to run out during a quarter. During fiscal year 1976-1977, expenditures totalled $1,496,403. During the 1977-78 fiscal year, $950,793.26 was spent on drugs by the state. The other major expenditures included approximately $105,000 for physician services, $124,000 for hospital services, $67,000 for dental services, $20,000 for vision care services, $28,000 for x-ray and lab services, and $20,000 for burial services.

These figures do not reflect a separate appropriation for those individuals over the 300 per cent cap. In addition, there is a special eyeglass and hearing aid fund. This is a matching fund for the elderly with patient cost-sharing. There are 3 categories of cost-sharing, 95 per cent, 75 per cent, and 50 per cent, depending on income and resources.

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U.S. Department of
Health, Education, and Welfare
Health Care Financing Administration
HEW Publication No (HCFA) 03013 9-79